WEA Trust

Short Term Disability Plan

A WEA Insurance Corporation
Group Short Term Disability Policy

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P.O. Box 7338 (53707-7338)
Madison, Wisconsin
Voice/TDD:
608-276-4000
1-800-279-4000

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IC-2808-258-0600

Important Notice

(Keep this notice with your insurance papers)

Problems with your insurance?

If you are having problems with WEA Insurance Corporation, do not hesitate to call or write WEA Insurance to resolve your problem. The address and phone numbers are:

WEA Insurance Corporation
P.O. Box 7338
Madison, WI 53707-7338
Voice/TDD: 1-800-279-4000 or 608-276-4000

You may also write the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. The address is:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or, you may call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

IC-2808-258-0600

Group Short Term Disability Policy

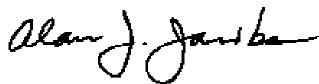
WEA Insurance Corporation

This is a short term disability insurance policy. It reimburses a specified weekly amount to a Disabled employee to offset income lost when a covered employee is Disabled. To be eligible for benefits under this policy, the covered employee must be unable to perform adequately the material and substantial duties of his or her Regular Occupation due to involuntary and medically proven physical or mental impairment(s).

The WEA Insurance Corporation hereby agrees to provide benefits in accordance with all of the provisions, exclusions, and limitations of this policy.

IN WITNESS WHEREOF, the WEA Insurance Corporation, by its President and Vice President, has executed and attested this policy.

President,



WEA Insurance Corporation
Madison, Wisconsin

Vice President,

WEA Insurance Corporation
Madison, Wisconsin

Table of Contents

Section 1 - Rights and Obligations of the Covered Employee and the WEA Insurance Corporation 1

Participation Requirements 1
Premium Obligations 1
When Premiums Are Due 2
Grace Period 2
Waiver of Premium 2
What Happens if You Lose Coverage Due to Nonpayment of Premium 2
Termination of This Policy 3
Information Required From the Employer 3
Entire Contract and Changes 3
Conformity With State Statutes 3
Statements by Our Employees or Agents 3
Incontestability 3
W-2 Reporting 3

Section 2 - Definitions That Apply to All Provisions 4

Section 3 - Eligibility and Dates of Coverage 6

Who is Eligible 6
How to Obtain Coverage 6
When You Are Eligible and When Coverage Begins 7
Current Employees 7
New Employees 7
Applying for a Level of Benefits That Requires Evidence of Insurability 7
Waiver of Evidence of Insurability in Special Circumstances 8
Applying for a Change in Your Level of Benefits 8
Late Enrollment Rules 8
Suspension of Coverage During Military Leave 8
Other Leaves 9
When Coverage Ends 9

Section 4 - Your Benefits and How You Qualify for Them 10

How You Qualify for Benefits 10
Benefit Amount 10
When Benefits Begin 10
When Benefits End 10
Recurrent Disability 11
Provisions That Apply in Special Circumstances 11
When Benefits Are Paid 12
Benefits During Rehabilitation 12
Your Obligations During a Period When You Are Entitled to Benefits Under This Policy 12
Your Obligations During a Period When You Are Entitled to Long Term Disability Benefits 12

Benefit Limitations 13
Limitation on Pre-existing Conditions 13
Exceptions to This Limitation on Pre-existing Conditions 13
Non-Compliance Limitation 13
Our Right to Examine 14
Change in Benefits 14

Section 5 - Exclusions, Limitations, and Reductions 15

Section 6 - Claims Procedure 17

Notice of Claim 17
Proof of Loss 17
Timeliness of Filing Claims 18
Continuing Proof of Loss 18
Costs Incurred for Substantiating Entitlement to Benefits 18
Our Right of Review and Recoupment 18

Section 7 - Your Rights in the Event of a Claim Denial 19

Right to a Full and Fair Review of Your Claim 19
Right to Appeal a Denial of Your Claim 19
Right to File a Complaint With the Office of the Commissioner of Insurance 19
Legal Actions 19

Appendix 20

Examples of How We Apply Policy Provisions to Pregnancy 20
Examples of How We Apply the Limitation on Pre-existing Conditions 22
Examples of How We Apply the Definition of “Period of Disability” to Recurrent Disability 23
Examples of How We Apply the Waiver of Premium Provisions 25

Section 1

Rights and Obligations of the Covered Employee and the WEA Insurance Corporation

This is a short term disability insurance policy for employees of eligible employers. It reimburses a specified weekly amount to a Disabled employee to offset income lost during the elimination or qualifying period of a Long Term Disability (LTD) policy. Therefore, the Maximum Benefit Period will correspond with the Elimination Period of the employer's LTD policy, if any. However, this policy will also be available for purchase by employees whose eligible employer does not provide LTD coverage but desires to make this policy available to its employees.

Participation Requirements

The coverage this insurance policy provides is available for purchase by employees of an eligible employer. An eligible employer has at least one employee group represented by an affiliate of the Wisconsin Education Association Council participating in this plan.

This policy is effective on the date specified in our insurance agreement with the employer if all of the following participation requirements are met. If the participation requirements are not maintained, we may terminate the policy for all employees.

1. At least 10 eligible employees or 10% of the total number of eligible employees, whichever is less, purchase this insurance coverage.
2. The covered employee contributes 100% of the premium from after-tax dollars.
3. The employer's plan that provides the benefits of this policy to its employees satisfies the nondiscrimination requirements in effect under sections 501(c)(9) and 505(b) of the Internal Revenue Code.

Premium Obligations

You are responsible for paying the premium for your coverage from after-tax dollars. This means, for example, that you cannot pay the premium through a Flexible Spending Account, or deduct the premium from your personal income for tax purposes. Your employer will collect the monthly premium from you, by payroll deduction or other means, and transmit it to us when it is due.

Premium is due for each month you are covered by this policy for at least a day. There is one exception: If your initial coverage begins after the 15th of a month, your premium liability will not begin until the first day of the following month.

Payment of premium does not obligate us to cover you under this policy if you are not eligible according to its provisions. Additionally, payment of premium does not obligate us to provide benefits to you unless you substantiate your Disability and fulfill all of your obligations under this policy.

The premium will always be based on the rates for the benefits that are in effect on the date that premium is due. We have the right to set new premium rates on either of the following dates:

1. Any date premium is due, if we notify you at least 31 days before the new rate takes effect.
2. Any date on which any provision of this policy is materially changed.

We will never increase premium rates 25% or more without notifying you at least 60 days in advance.

When Premiums Are Due

The monthly premium for all covered employees is payable to us on or before the 20th of the month preceding the month of coverage.

Note: Your premium obligation continues during a period in which you are eligible to receive benefits under this policy. If we do not receive the premium, your benefits and coverage under this policy will end on the last day of the month for which the last premium was paid.

Grace Period

We allow a grace period of 31 days for the receipt of any premium due after the first premium. This means that if premium is not paid on or before the date it is due, it may be paid during the following 31 days. This policy will continue in force during the grace period. If we do not receive the premium payment within the grace period, coverage will automatically end on the last day of the month for which the last premium was timely paid. No grace period applies, however, if either the employer or we have given written notice to the other of the termination of this policy. Similarly, no grace period applies if you have notified us that you are terminating your coverage.

Waiver of Premium

We will waive the premium during a period in which you are eligible to receive Long Term Disability benefits. Unless you are covered by our Long Term Disability Policy, you must let us know when you become eligible for Long Term Disability benefits and send us evidence of the date on which you became eligible for those benefits. For example, we will accept as evidence a copy of the letter in which your insurer confirms approval of Long Term Disability benefits. This information allows us to document your right to maintain coverage without paying premium.

You must also notify us when your Long Term Disability benefits cease and provide evidence of the date on which the benefits ended. Your premium obligation resumes on the earlier of these dates:

- The date your Long Term Disability benefits cease.
- The first day on which you are no longer Disabled.

If you do not resume paying premiums on the first premium due date on or after your premium obligation resumes, your coverage under this policy will end on the date your premium obligation resumed.

What Happens if You Lose Coverage Due to Nonpayment of Premium

If your coverage ends because you did not pay, or resume paying, your premium as required, and you wish to re-enroll later, you will be subject to the rules for late enrollment on page 8. In addition, we will treat your re-enrollment as a new enrollment. This has two consequences:

1. You will not be enrolled unless you provide evidence of insurability that we, in our sole discretion, deem acceptable; and
2. We will not pay benefits for a Disability that begins during the first 12 months that your re-enrollment coverage is in effect if that Disability was caused by, or related to, a condition for which, in the 12 months before your re-enrollment became effective, you:
    - Received medical treatment;
    - Took prescribed drugs; or
    - Consulted a Physician, whether in person, by phone, or by any other means.

Termination of This Policy

You, your employer, or we may terminate this policy under these conditions:

- Your employer may terminate the policy for all employees on the first day of any month by notifying us in writing at least 31 days before that date.
- You may terminate your coverage effective at the end of any month by informing your employer or us in advance.
- We may terminate this policy if the participation requirements or premium obligations are not met. In that case, we will notify you and your employer in writing at least 31 days before the termination date.
- We may terminate this policy for any legally permissible reason by notifying you and your employer in writing at least 60 days before that date.

Information Required From the Employer

Your employer is required to give us any information we deem necessary to administer this policy. Examples include, but are not limited to:

- Your salary and wage information.
- Verification of your absence from work.
- Verification that you are a member of the eligible class of employees.

Entire Contract and Changes

The entire contract consists of:

1. This policy and any amendments;
2. Your letter of Confirmation of Enrollment or Change of Coverage;
3. Your enrollment form;
4. Your Evidence of Insurability Form, if required; and
5. The insurance agreement between your employer and us.

No change in this policy is valid unless it is written and signed by one of our officers. No agent may change the policy or waive any of its provisions.

Conformity With State Statutes

Any provision of this policy which conflicts with the statutes of the state in which the policy is issued is hereby amended to conform to the minimum requirements of those statutes. The effective date of any such required amendment will be the latest date permitted by those statutes.

Statements by Our Employees or Agents

No statement or representation by any of our employees or agents can alter or waive any of the requirements or provisions of this policy. No statement or representation with respect to the interpretation or application of any provision of this policy is binding on us unless an officer of our company issues it in writing.

Under no circumstances will your employer be deemed our agent without our written authorization.

Incontestability

We will not use any statement you make, except a fraudulent misstatement, to contest the validity of your coverage under this policy after your coverage has been in effect for two consecutive years.

W-2 Reporting

We will issue each year, to both you and the Internal Revenue Service, the required W-2 forms for reporting benefits paid under this policy.

Section 2

Definitions That Apply to All Provisions

The terms defined below appear throughout this policy. When these terms are capitalized in the text of the policy, they have the meaning defined below.

Whenever the words "you" or "your" appear in the policy, they refer to a covered employee. The exception to this is Section 3–Eligibility and Dates of Coverage where "you" and "your" refer to any employee of the employer. Whenever the terms "we," "us," and "our" appear, they refer to the WEA Insurance Corporation.

Annual Salary means your total wage compensation, as reported by your employer, that you earn in exchange for the performance of a normal year of service to your employer at your current rate of pay. It does not include any overtime or bonus pay. If you become Disabled during the period between school years, and you do not regularly work for your employer during those months, your Annual Salary is that which you were receiving at the end of the preceding school year.

Date of Disability means the date that we determine to be the first day on which you were Disabled. We determine your Date of Disability based on these:

- Statements provided by you, your employer, and your Physician on our claim form; and
- Objective, contemporaneous medical evidence including, but not limited to, medical records we deem necessary to investigate and administer your claim.

Disabled and **Disability** mean your inability to perform adequately the material and substantial duties of your Regular Occupation due to your own involuntary and medically proven physical or mental impairment(s). The physical or mental impairment(s) causing your Disability must be substantiated in objective, contemporaneous medical records and documentation.

Elimination Period means the period of consecutive calendar days, beginning on the Date of Disability, for which no benefits will be paid to you after we have determined you are Disabled.

Injury means bodily injury, caused by an accident, which in and of itself results in a Disability within 90 days. Benefits will be payable only if the Injury occurs while this insurance is in effect.

Long Term Disability refers to a group income replacement policy, or benefits of a group income replacement policy, sponsored by your employer.

Maximum Benefit Period means the greatest number of days for which benefits are payable for any one Period of Disability. The Maximum Benefit Period is shown in your letter of Confirmation of Enrollment or Change of Coverage.

Period of Disability means one continuous period of Disability beginning on your Date of Disability, including the Elimination Period, and ending on the date of your death or the date you cease to be Disabled. Successive periods of Disability will be deemed the same Period of Disability unless:

- Due to an unrelated cause and separated by your return, or your ability to return, to

the regular performance of your job duties for your employer; or

- Due to the same or related cause but separated by your return, or your ability to return, to the regular performance of your job duties for your employer for six consecutive months, including summer months.

Physician means a qualified practitioner other than you or a member of your immediate family (i.e., spouse, parent, sibling, or child) who is licensed to diagnose and treat the physical or mental impairment(s) causing your Disability. This definition includes only the following practitioners, and only to the extent that the services provided are within the scope of the individual practitioner's professional license:

- M.D. - Doctor of Medicine
- D.O. - Doctor of Osteopathy
- D.S.C. - Doctor of Surgical Chiropody
- D.P.M. - Doctor of Podiatric Medicine
- O.D. - Doctor of Optometry
- D.C. - Doctor of Chiropractic
- D.D.S. - Doctor of Dental Surgery
- D.M.D. - Doctor of Medical Dentistry

Regular Care of a Physician means:

- You are being seen by a Physician at intervals of time appropriate for treating your disabling impairment(s);
- Your Physician is rendering and/or prescribing a pertinent treatment plan or a practical protocol, if one exists, for alleviating or eliminating the impairment(s) causing the Disability; **and**
- You are complying with all aspects of the Physician-prescribed treatment plan.

Regular Occupation means the position you held with your employer on your Date of Disability. If you become Disabled during the period between school years, and you do not regularly work for your employer during those months, your Regular Occupation is the position you held at the end of the preceding school year.

Sickness means any cause of Disability not excluded in Section 5–Exclusions, Limitations, and Reductions that does not qualify as an *Injury* as we have defined it above. Sickness, for purposes of this policy, includes pregnancy, childbirth, and related medical conditions. It also includes Disability caused by an Injury that occurred more than 90 days before the onset of the Disability.

Section 3

Eligibility and Dates of Coverage

This section describes who is eligible for coverage under this policy. It explains when those individuals become eligible, when their coverage begins, and when coverage ends.

Note: Whenever the terms "you" or "your" appear in this section, they refer to an employee of the employer who signed the insurance agreement for this Group Short Term Disability Policy.

The date you become eligible for coverage is subject to the waiting period, if any. The waiting period is the period of time you must be continually at work for your employer before you are eligible for coverage under this policy. The length of the waiting period, if any, is established by your employer and is specified in the insurance agreement between your employer and us.

Who Is Eligible

You are eligible for coverage if:

- You are a member of the eligible class of employees specified by your employer; and
- You are actively at work for your employer, performing all of your job duties.

If you are an employee who is on a leave of absence when this policy takes effect, you are not eligible for coverage until you resume the active, regular performance of all of your job duties as a member of the eligible class of employees at the end of the leave.

Similarly, if you would be an employee except that you are Disabled on the date this policy takes effect, you are not eligible for coverage until you are no longer Disabled and you resume the active, regular performance of all of your job duties as a member of the eligible class of employees.

How to Obtain Coverage

To obtain coverage, you must submit an enrollment form within 30 days of the date you are first eligible. If you apply after the 30-day period, your enrollment will be subject to the "Late Enrollment Rules" on page 8.

In addition to the enrollment form, we also require evidence of insurability that we, in our sole discretion, deem acceptable if you apply for coverage at a benefit level that requires it. The enrollment form indicates which benefit levels require evidence of insurability. You must provide evidence of your insurability, if required, without cost to us.

Note regarding evidence of insurability: In each case where evidence of insurability is required, we base our decision whether to approve your coverage on the information you provide on the Evidence of Insurability form. We monitor all claims for two years following our approval. If, during that period, we learn that the information we relied on was incorrect, or relevant information was omitted, we may retroactively rescind coverage and deny claims.

Two distinct dates play a role in determining when your coverage under this policy begins. As you read this section, you will want to keep them in mind. They are:

1. The date you become eligible for coverage.
2. The date your coverage actually begins.

When You Are Eligible and When Coverage Begins

Current Employees

You are eligible for coverage on the date this policy takes effect. Your coverage begins on that date if:

- You submit an enrollment form to us **before** the effective date; and
- You are actively at work for your employer, performing all of your job duties, on the effective date.

If you apply **during** the first 30 days that this policy is effective, your coverage will begin on the date you sign the enrollment form if you are actively at work for your employer, performing all of your job duties on that date.

If you are either Disabled or absent from work on the date your coverage would otherwise take effect, your coverage will not begin until the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

New Employees

You are eligible for coverage on the date you begin the active performance of your regular job duties. Your coverage will begin on that day if:

- You submit an enrollment form to us **before** the date you begin work; and
- You are actively at work for your employer, performing all of your job duties.

If you apply **during** the first 30 days after you begin your employment, your coverage will begin on the date you sign the enrollment form if you are actively at work for your employer, performing all of your job duties on that date.

If you are either Disabled or absent from work on the date your coverage would otherwise take effect, your coverage will not begin until the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

Applying for a Level of Benefits That Requires Evidence of Insurability

The enrollment form indicates which benefit levels require evidence of insurability. If you apply for coverage at one of these benefit levels, coverage at that level will not take effect until the first day of the month following our approval of your evidence of insurability. If you are either Disabled or absent from work on the date that the approved level of benefits would otherwise be effective, the approved benefit level will not take effect until the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

While we are considering your application and evidence of insurability for the requested benefit level, we will enroll you in the highest benefit level for which you are eligible without evidence of insurability. There is an exception to this: If your application is subject to the Late Enrollment Rules below, you will not be enrolled at any benefit level until the first day of the month following our approval of your application and evidence of insurability.

Waiver of Evidence of Insurability in Special Circumstances

We waive our initial evidence of insurability requirement if both of these apply:

- Your coverage under a previous group short term disability policy sponsored by your employer ended because your employer switched to this policy; and
- There was no lapse in coverage between the policies.

In these circumstances, you may enroll in this policy, without evidence of insurability, at the benefit level equal to, or next higher than, the benefit level in which you were enrolled under the previous policy, provided you enroll within 30 days of becoming eligible.

We also apply these same waiver provisions regarding evidence of insurability if you are a new employee who was covered by our Group Short Term Disability Policy while working for a previous employer, and you had no lapse in coverage.

Applying for a Change in Your Level of Benefits

If, after you are enrolled, you want to apply for a higher weekly benefit level, you must submit a new enrollment form and an evidence of insurability form. If we approve your application and evidence of insurability, coverage at the new benefit level will take effect on the first day of the month following our approval. If you are either Disabled or absent from work on the date that the approved level of benefits would otherwise be effective, the approved new benefit level will not take effect until the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

If, after you are enrolled, you want to reduce your weekly benefit level, you may do so, without evidence of insurability, by submitting a new enrollment form, indicating the desired benefit level. The new lower level of benefits will take effect on the first day of the month following the date you signed the enrollment form.

A change in your level of benefits will not apply to a Period of Disability that begins in the first 12 months after the change is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before the change took effect, you:

- Received medical treatment;
- Took prescribed drugs; or
- Consulted a Physician, whether in person, by phone, or by any other means.

Late Enrollment Rules

If you submit an enrollment form to us more than 30 days after you become eligible for coverage, you will be denied coverage unless you provide evidence of insurability that we, in our sole discretion, deem acceptable. If we approve your enrollment, your coverage will begin on the first day of the month following our approval if you are not Disabled or absent from work on that day. If you are either absent from work or Disabled on the date your coverage would otherwise take effect, your coverage will begin on the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

Suspension of Coverage During Military Leave

If you are a covered employee who is taking a military leave of absence, we will suspend your coverage for a maximum of one year as described below. This includes military leave for active duty (including periods of annual training) in the National Guard or any active or reserve component of the military forces of any state or the United States.

Suspension of coverage means all of the following:

- You are not liable for premiums.
- You are not eligible for benefits.
- We will maintain your insurability at the benefit level in effect on the day before your military leave began.
- The length of time you are on military leave may be used to satisfy the 12-month pre-existing condition limitation. (See “Limitation on Pre-existing Conditions” on page 13.)

To ensure continued coverage on the above basis following a military leave, you must call our Eligibility Department or complete an enrollment form within 30 days of your return to the active, regular performance of job duties for your employer. You or your employer must also inform us that you are re-enrolling after a military leave.

Other Leaves

You are not eligible to continue coverage while you are on a leave of absence other than a military leave of absence or an employer-granted leave while you are Disabled. Therefore, your coverage under this policy will end on the first day of a leave of absence, whether paid or unpaid, except for military leaves up to a maximum of one year or for Disability leaves.

When Coverage Ends

Your coverage under this policy will end on the earliest of the following dates:

- The date this policy terminates for any reason.
- The last day of the month for which the last premium was timely paid for your coverage.
- The date you cease to be an employee, cease to be a member of the eligible class of employees, or otherwise cease to be eligible for coverage by this policy.
- The date that is one year from the date on which your coverage was suspended while you were on military leave, unless you return to work on or before this date and immediately re-enroll as required.
- The date you begin a leave of absence other than a military leave or a leave of absence while you are Disabled.
- The date on which you, if you were Disabled on the date this policy ceases to cover the eligible class of employees to which you belonged, return to active work, or could have returned to work, for your employer, or exhaust the Maximum Benefit Period for your Period of Disability, whichever occurs first.

Section 4

Your Benefits and How You Qualify for Them

This section describes your benefits and how you qualify for them. It also explains your responsibilities under the policy and your obligations during a period when you are entitled to benefits.

How You Qualify for Benefits

You qualify for benefits if:

- You are Disabled;
- You have substantiated your Disability as required in Section 6–Claims Procedure; **and**
- You are fulfilling all obligations of this policy.

Benefit Amount

The weekly benefit payable is specified in your letter of Confirmation of Enrollment or Change of Coverage. If you are Disabled, we will pay benefits at that rate provided it does not exceed 66 2/3% of your weekly salary. Weekly salary is Annual Salary divided by 52.

If the weekly benefit shown in your letter of Confirmation of Enrollment or Change of Coverage exceeds 66 2/3% of your weekly salary, we will reduce our payment to 66 2/3% of your weekly salary.

Because benefits are payable for each calendar day of Disability, any benefit payable for less than a week will be computed at a daily rate equal to 1/7th of the weekly benefit.

When Benefits Begin

Benefits are payable after you have been Disabled for the duration of the Elimination Period. The Elimination Period begins on your Date of Disability as determined by us. The Elimination Period for Disability due to Sickness is three days; there is no Elimination Period for Disability due to an Injury. Therefore, benefits are payable on the first day of Disability due to Injury, but only if you meet one of the following criteria:

- You are treated by a Physician on the day you are injured; or
- If your Injury occurs on a school day, you are treated by a Physician within three days of the Injury.

Otherwise, benefits for a Disability due to an Injury will not begin until the day you are first treated by a Physician for that Injury.

Benefits are payable on the fourth day of Disability due to Sickness.

When Benefits End

We will pay benefits until the earliest of the following dates:

- The date on which you have exhausted the Maximum Benefit Period for your Period of Disability. The Maximum Benefit Period is specified in your letter of Confirmation of Enrollment or Change of Coverage.

- The date you are no longer Disabled. We will generally deem you to be no longer Disabled when you are able to perform 80% or more of the material and substantial duties of your Regular Occupation.
- The date of your death.
- The date on which you fail to provide proof satisfactory to us that you remain Disabled, whether or not you return to work.
- The date you return to work for your employer for any part of a day except as provided below under "Benefits During Rehabilitation."
- The date you become eligible for Long Term Disability benefits.

If we suspend benefits under this policy for 60 consecutive days due to your failure to comply with all of the requirements of this policy, we can irrevocably terminate all further benefits under this policy.

If this policy ends while you are entitled to benefits, we will continue to pay your benefits until the earliest of the above dates if you continue to pay the required premiums.

Recurrent Disability

There are circumstances under which occurrences of Disability separated by a return to work, or the ability to return to work, are considered one Period of Disability. We call this recurrent Disability, and it occurs in the following circumstances:

- You return to work for your employer, or could have returned to work, from a previous Disability; **and**
- You become Disabled again due to the same or related cause within six months (including summer months) after you returned to work or could have returned to work. This is a recurrent Disability.

If you experience a recurrent Disability, you are eligible for benefits immediately, without satisfying a new Elimination Period. However, you are eligible for benefits only for the number of days remaining in the Maximum Benefit Period after the previous length(s) of Disability has been subtracted.

We will determine your subsequent occurrence of Disability to be a new Period of Disability, and not a recurrent Disability, under these circumstances:

- You return to work for your employer, or could have returned to work, from a previous Disability; **and**
- You become Disabled due to an unrelated cause; **or**
- You become Disabled due to the same or related cause, but your Disability occurs six months or more (including summer months) after you returned to work or could have returned to work.

In these circumstances, you experience a new Period of Disability. This means you must fulfill a new Elimination Period, if any, and you are eligible for a new Maximum Benefit Period.

Note: You are not eligible for benefits due to a recurrent or new Period of Disability if you are on a leave of absence, have retired, or are otherwise no longer considered an employee.

Provisions That Apply in Special Circumstances

This subsection summarizes how we will apply our provisions regarding recurrent Disability, explained above, in cases where the original Disability occurred under a previous policy and the Disability recurred under this policy. We will apply these provisions to you if your coverage under a previous employer-sponsored group short term disability policy ended because your employer switched to this policy, and you had no lapse in coverage:

- The Date of Disability is that which the previous insurer determined. The Period of Disability begins on that date.
- The weekly benefit payable under this policy is the same weekly benefit that was payable under your previous policy for this Period of Disability. There is an exception: If you are enrolled in a lower benefit level under this policy, the weekly benefit payable is the lower level in which you are enrolled.

- Your Regular Occupation is the job you held on your Date of Disability.
- The Maximum Benefit Period in effect on your Date of Disability under the previous policy applies.

We will also apply these same provisions regarding recurrent Disability if you are a new employee who was covered by our Group Short Term Disability Policy while working for a previous employer, and you had no lapse in coverage.

When Benefits Are Paid

After we have determined that you qualify for benefits, we will pay benefits monthly, at the end of the month. Note that if you qualify for benefits, we will also pay benefits during a Period of Disability when school is not in session.

Benefits During Rehabilitation

We recognize that many Disabled employees will need to resume partial work responsibilities in the process of recovering from a Disability and regaining the ability to work full-time. We encourage you to do this. Therefore, if we have pre-approved the continuation of benefits in the context of your partial return to work, we will continue to pay your benefits, subject to the Maximum Benefit Period.

Your Obligations During a Period When You Are Entitled to Benefits Under This Policy

To receive benefits during a Period of Disability, you must fulfill all of these obligations. If you do not, you will lose your entitlement to benefits.

- You must arrange for and use the Regular Care of a Physician. In addition, you must pursue any reasonable medical procedure or treatment that would likely improve your condition or end your Disability and that does not pose unreasonable risks.
- You must submit periodic evidence from your Physician that substantiates to our satisfaction that you remain Disabled. This required evidence includes, but is not limited to, objective, contemporaneous medical and/or psychiatric evidence that confirms your Disability. You must provide this information at your own expense.
- Where they exist, you must engage in appropriate medical and/or occupational rehabilitation programs that are reasonably expected to enable you to return to work. We ask that you notify us when you participate in such a program.
- You must promptly provide us with all information that we reasonably decide is necessary to verify and administer your claim for benefits.
- You must make a good faith effort to recover from, or reduce the severity of, your Disability.
- You must continue payment of premiums.

Your Obligations During a Period When You Are Entitled to Long Term Disability Benefits

Unless you are covered by our Long Term Disability Policy, you must notify us when you become eligible to receive Long Term Disability benefits and send us evidence of the date on which you become eligible for those benefits. For example, we will accept as evidence a copy of the letter in which your insurer confirms approval of Long Term Disability benefits. This information allows us to document your right to maintain coverage without paying premium.

You must also notify us when your Long Term Disability benefits cease for any reason and provide evidence of the date on which the benefits ended. Your premium obligation resumes on the sooner of these dates:

- The date you cease receiving Long Term Disability benefits.

- The date you are no longer Disabled.

If you do not resume premium payment on the first premium due date on or after your premium obligation resumes, your coverage under this policy will end on the date your premium obligation resumed. If coverage ends because you failed to resume premium payment, and you later wish to re-enroll, your subsequent enrollment will be treated as a new enrollment and you will be subject to the "Late Enrollment Rules" on page 8. This has two consequences:

1. You will not be re-enrolled unless you provide evidence of insurability that we, in our sole discretion, deem acceptable; and
2. We will not pay benefits for a Disability that begins during the first 12 months after your re-enrollment coverage is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before your re-enrollment became effective, you:
   - Received medical treatment;
   - Took prescribed drugs; or
   - Consulted a Physician, whether in person, by phone, or by any other means.

Benefit Limitations

Limitation on Pre-existing Conditions

Benefits will not be paid for a Disability that begins in the first 12 months after your coverage is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before your coverage became effective, you:

- Received medical treatment;
- Took prescribed drugs; or
- Consulted a Physician, whether in person, by phone, or by any other means.

Exceptions to This Limitation on Pre-existing Conditions

We will waive this 12-month limitation if both of the following apply:

- Your coverage under a previous group short term disability policy sponsored by your employer ended because your employer switched to this policy; and
- You had no lapse in coverage between the two policies.

We will also waive this 12-month limitation if both of the following apply:

- You are a new employee who was covered by our Group Short Term Disability Policy when you worked for your previous employer; and
- You had no lapse in coverage.

In these cases, we will pay the benefit amount under this policy that most closely approximates the benefit amount you would have been entitled to under the previous policy if either of the following applies:

- The period of time you were continuously covered by the previous policy and this policy is 12 months or more; or
- Your claim would not have been barred by any pre-existing condition limitation in the previous policy had you remained covered under that plan until you incurred the claim.

Non-Compliance Limitation

You are not entitled to benefits under this policy for any portion of a Period of Disability during which you are not complying with the requirements of this policy. Therefore, we will suspend your benefits during such a period of non-compliance. If benefits under this policy are suspended for 60 consecutive days due to your failure to comply with all of the requirements of this policy, we can irrevocably terminate all further benefits under this policy.

You are not entitled to benefits under this policy during a Period of Disability in which benefits under a Long Term Disability policy have been suspended because you are not complying with that policy's requirements; for example, you are not under the Regular Care of a Physician as required by the Long Term Disability policy.

Our Right to Examine

We have the right to require that you be examined by a health care professional of our choice and at our expense, when and as often as it is reasonable with respect to any claim for benefits.

We also have the right to require your cooperation in a vocational assessment by a vocational expert of our choice and at our expense, when and as often as it is reasonable with respect to any claim for benefits.

Change in Benefits

If your benefits or level of benefits change, the new benefits or benefit level will become effective on the date of the change if you are not Disabled and you are actively at work for your employer, performing all of your job duties.

Otherwise, the change will take effect on the date you are no longer Disabled **and** you:

- Resume the active, regular performance of all of your job duties; or
- Could have resumed the active, regular performance of all of your job duties if school were in session.

In no event will a change in your benefits or level of benefits take effect **during** a Period of Disability.

In addition, a change in your level of benefits will not apply to a Period of Disability that begins in the first 12 months after the change is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before the change took effect, you:

- Received medical treatment;
- Took prescribed drugs; or
- Consulted a Physician, whether in person, by phone, or by any other means.

Section 5
Exclusions, Limitations, and Reductions

The policy's benefits are subject to the exclusions, limitations, and reductions listed in this section.

1. Benefits are not payable with respect to any Disability:
   - That is caused or contributed to by intentionally self-inflicted injuries or attempted suicide.
   - That results from service in the armed forces of any country or results from an act of war, whether declared or undeclared.
   - That occurs during any military leave for active duty, including training duty, in the National Guard or any active or reserve component of the military forces of any state or country including the United States.
   - Arising from your participation in committing a crime.
2. Benefits will not be paid for a Disability, or portion thereof, during which:
   - You are not under the Regular Care of a Physician.
   - You fail to satisfy your obligations as described in this policy.
   - You are incarcerated for any reason.
   - You are eligible to receive Long Term Disability benefits.
3. Benefits are not payable during a period in which benefits under a Long Term Disability policy have been suspended due to your non-compliance with that policy's requirements; for example, you are not under the Regular Care of a Physician as required.
4. If the weekly benefit shown in your letter of Confirmation of Enrollment or Change of Coverage exceeds 66 2/3% of your weekly salary, the benefit will be reduced to 66 2/3% of your weekly salary.
5. Benefits will not be paid for a Disability that begins in the first 12 months after your coverage is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before your coverage became effective, you:
   - Received medical treatment;
   - Took prescribed drugs; or
   - Consulted a Physician, whether in person, by phone, or by any other means.
6. A change in your level of benefits will not apply to a Period of Disability that begins in the first 12 months after the change is in effect if that Disability was caused by, or related to, any condition for which, in the 12 months before the change took effect, you:
   - Received medical treatment;
   - Took prescribed drugs; or
   - Consulted a Physician, whether in person, by phone, or by any other means.

7. We have the right to suspend benefit payments during any period in which you are non-compliant with the policy's requirements. If we suspend your benefits for 60 consecutive days due to your failure to comply, we can irrevocably terminate all further benefits under this policy.
8. We will not pay for any costs you incur in establishing evidence of your insurability, or substantiating your initial or ongoing eligibility for benefits.

Section 6

Claims Procedure

This section tells you how to file a claim for benefits. Before you may receive benefits, you must give us notice of your claim and provide acceptable proof of loss. The notice of claim informs us of your claimed Disability. The proof of loss substantiates that you are eligible for benefits.

The notice of claim and proof of loss must be provided to us within 90 days of becoming Disabled. Wisconsin law extends this time to 12 months beyond the 90 days required by this policy, but only if we are not prejudiced by the delay and it was not reasonably possible for you to meet our 90-day time limit.

We will not pay for any costs you incur in substantiating your initial or ongoing entitlement to benefits. This includes, but is not limited to, the cost of completing forms and copying and transmitting medical documentation.

Notice of Claim

To initiate a claim for benefits, you must send us written notice of your claim as soon as possible, but within 90 days of becoming Disabled. This notice alerts us to the existence and nature of your claim. It also allows us to obtain the information and documents we need to process your claim in a timely manner.

You must submit this written notice to us on our claim form, which you can obtain from your employer or from us. To obtain a claim form from us, call our Disability Department at 1-800-279-4000. We will mail the requested claim form within 10 days of receiving your request.

The information required on the notice of claim includes the following:

- Your name, address, and social security number.
- Your occupation.
- The name of your employer.
- The date you were first unable to work.
- The last date you were at work.
- Your Annual Salary on the date you became Disabled.
- The nature of the Sickness or Injury that caused your claimed Disability.
- The name of the Physician(s) who diagnosed and treated you.

Proof of Loss

To substantiate your claim for benefits, you must provide proof of your Disability that we consider sufficient. Proof of loss must be provided to us as soon as possible, but within 90 days of becoming Disabled.

Proof of loss will not be complete until you, your employer, your treating Physician(s), and the objective, contemporaneous medical evidence have substantiated to our satisfaction that you are Disabled. To substantiate your Disability, we will require information from your employer regarding your inability to perform the duties of your Regular Occupation. We will also require objective, contemporaneous evidence

confirming your Disability from a Physician licensed and qualified to diagnose the impairment(s) causing your Disability, in addition to the information you provide yourself. A Physician's statement that you are Disabled, without accompanying objective, contemporaneous medical and/or psychiatric evidence, is not sufficient to substantiate your Disability.

Note: You are responsible for ensuring that your applicable medical records are attached to the claim form as required.

Timeliness of Filing Claims

We often find that our ability to accurately investigate and adjudicate claims of Disability is significantly reduced when the claim is filed more than three months after the claimed Date of Disability. Because our interest is prejudiced when claims are filed more than 90 days after the onset of the Disability, we reserve the right to deny such claims.

Continuing Proof of Loss

After you become eligible for benefits, we will regularly require proof of continuing Disability, including reports by your treating Physician which provide objective, contemporaneous medical and/or psychiatric evidence, to confirm your continued Disability. We will not consider continuing proof of loss to be sufficient if you are not under the Regular Care of a Physician.

Costs Incurred for Substantiating Entitlement to Benefits

We will not pay any cost you may incur in establishing initial and ongoing entitlement to benefits. For example, we do not reimburse charges for completing forms, legal expenses, or expenses for copying and providing medical or other information in support of a claim.

Our Right of Review and Recoupment

We review claims both before and after payment. Whenever we find that any information is fraudulent, misleading, inaccurate, or incomplete, we have the right to reevaluate and retroactively modify our claim payment. We have this right regardless of whether we have paid some or all of the claim.

If we erroneously make payments that exceed those you are entitled to, you must repay the excess, duplicate, or erroneous amount as soon as we notify you of the overpayment. If you delay in reimbursing us, we have the right to charge reasonable interest on the delinquent amount. We also have the right to discontinue benefit payments until the overpayment is resolved.

Our acceptance of premium or other fees, or our paying benefits, does not waive our rights to enforce the provisions of this section in the future. The provisions in this section are in addition to, and not in lieu of, any other rights or remedies available to us at law or in equity.

Section 7

Your Rights in the Event of a Claim Denial

If you believe that you have not received the benefits to which this policy entitles you, you have certain rights under this policy and by law to seek a resolution of your complaint. This section explains those rights.

Right to a Full and Fair Review of Your Claim

You have the right to a full and fair review of your claim. Our review includes all evidence of your entitlement to benefits that you submit within the time required by this policy. You also have the right to examine any document in our possession that is relevant to your claim. Following our review, we send you a written explanation of the reason(s) for our denial of any claim, including reference to the policy provisions on which we are basing our denial.

Right to Appeal a Denial of Your Claim

You have the right to appeal the denial of a claim for benefits to our Board of Directors in accordance with our Appeal Procedure, if we receive your appeal within 60 days of the date on our final notice of denial of the claim. The Appeals Committee of the Board of Directors will issue a written decision on the appeal.

To obtain a written explanation of the procedures and requirements of our Appeal Procedure, including any necessary forms, write to our President or General Counsel at WEA Insurance Corporation, P.O. Box 7338, Madison, WI 53707-7338.

Right to File a Complaint With the Office of the Commissioner of Insurance

You also have rights under the law. One of those is the right to file a complaint with the **Office of the Commissioner of Insurance**, a state agency that enforces Wisconsin's insurance laws. You can contact the **Office of the Commissioner of Insurance** by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or, you can call 1-800-236-8517 outside of Madison, or 608-266-0103 in Madison, and request a complaint form.

Legal Actions

You may not bring an action at law or in equity to recover on this policy unless you have exhausted our Appeal Procedure. In addition, you cannot bring such an action after the expiration of three years from the date your claim was required to be submitted. However, the three-year period within which you may file a legal action will not include the period of time starting from the date we receive your timely appeal and ending on the date the Appeals Committee issues its written decision on the appeal.

Appendix

Examples of How We Apply Policy Provisions to Pregnancy

Example 1

- Ms. White has Short Term Disability (STD) coverage at a weekly benefit level of $175. She has been covered at this level for over two years.
- She applies to increase the weekly benefit level to $357. This benefit level requires evidence of insurability that we consider acceptable. She completes the Evidence of Insurability form and signs it on February 1; the school district sends it to us.
- We review the information on the Evidence of Insurability form in mid-February and approve coverage at the higher level as of March 1.
- On March 10, Ms. White calls and tells us that she has just found out she is pregnant. She is inquiring about the STD benefits available to her for her upcoming Disability related to childbirth. She tells us she did not see a physician for pregnancy before March 1, the effective date of the higher benefit level of $357. She maintains she did not know she was pregnant until she saw her Physician on March 10.
- Because the benefit level of $357 requires evidence of insurability that is acceptable to us, we now review the medical records to determine:
  1. When Ms. White became pregnant, and
  2. If it was reasonable to assume she was aware of her pregnancy when she applied for the higher benefit level.
- Ms. White's medical records indicate that:
  1. She had not seen a physician for pregnancy before March 10.
  2. On March 10, when she was examined, the physician determined that her approximate date of conception was November 1 and that she is approximately four months pregnant.

What benefit level will apply to Ms. White's subsequent Disability due to childbirth?

Our Decision and Rationale: She is entitled to benefits at the lower level of $175.

At the time Ms. White signed the Evidence of Insurability form on February 1, she was three months pregnant. Although she had not seen a Physician for this condition, it is reasonable to assume that she would have known that she was likely pregnant. Accordingly, she should have reported this on the form.

The Evidence of Insurability form states that we base our coverage decisions on the information provided to us on the form. Further, it states, "All claims will be monitored for two years following approval. If, during that period, we learn that the information we relied upon was incorrect, or relevant information was omitted, coverage may be retroactively terminated or claims may be denied."

Because we would not have approved benefits at the higher level had she reported a pregnancy on the Evidence of Insurability form, we will now rescind our approval of coverage at the $357 level. Her previous benefit level, $175 per week, will apply to her upcoming Disability due to childbirth.

Example 2

- Ms. Green has Short Term Disability (STD) coverage at a weekly benefit level of $175. She has been covered at this level for over two years.
- She applies to increase the weekly benefit level to $357. This benefit level requires evidence of insurability that we consider acceptable. She completes the Evidence of Insurability form and signs it on February 1; the school district sends it to us.
- We review the information on the Evidence of Insurability form in mid-March and approve coverage at the higher level as of April 1.
- On March 24, Ms. Green calls and tells us that she has just found out she may be pregnant. She is inquiring about the STD benefits available to her for her upcoming Disability related to childbirth. She tells us she has not yet seen a Physician to confirm the pregnancy and that she did not know she might be pregnant when she signed the Evidence of Insurability form on February 1.
- Because the benefit level of $357 requires evidence of insurability that is acceptable to us, we will now review the medical records to determine:
  1. When Ms. Green became pregnant, and
  2. If it was reasonable to assume she was aware of her pregnancy when she applied for the higher benefit level.
- Ms. Green's medical records indicate that:
  1. She saw a Physician for her pregnancy for the first time on April 26.
  2. On April 26, when she was examined, the Physician determined her expected delivery date to be October 20 and estimated that she is approximately three months pregnant.

What benefit level will apply to Ms. Green's subsequent Disability due to childbirth?

Our Decision and Rationale: She is entitled to benefits at the higher level of $357.

At the time Ms. Green signed the Evidence of Insurability form on February 1, she was no more than two weeks pregnant. Therefore, it is not reasonable to assume she knew she was pregnant at the time she applied for the higher benefit level. We reaffirm our approval of the higher benefit level of $357.

Example 3

- Now let's say that, in addition to all of the facts that apply to Ms. Green's circumstances above, her medical records also indicate that she was treated for infertility during the six months prior to becoming pregnant.

Is Ms. Green entitled to benefits for her upcoming Disability due to childbirth? If so, at what level of benefits?

Our Decision and Rationale: Ms. Green is entitled to benefits at the weekly rate of $175.

The policy provides, on page 14 under "Change in Benefits," that a change in the level of benefits will not apply to a Period of Disability that begins in the first 12 months after the change is in effect if that Disability was caused by, or related to, any condition for which you received medical treatment, took prescribed drugs, or consulted a Physician — whether in person, by phone, or by any other means — in the 12 months before the change took effect.

Because Ms. Green was treated for infertility, which is a condition related to pregnancy, in the 12 months before the higher benefit level of $357 per week became effective, she is not entitled to the new benefit level for her upcoming Period of Disability due to childbirth.

Examples of How We Apply the Limitation on Pre-existing Conditions

Read about the limitation that applies to pre-existing conditions on page 13 of this policy under "Benefit Limitations."

Example 1

- Mr. Black's Short Term Disability (STD) coverage was effective February 1 and has been in effect for six months when he undergoes sinus surgery on August 1.
- Mr. Black is Disabled from August 1 until August 12 as a result of the surgery.
- A review of his medical records reveals that he was treated with antibiotic therapy for several sinus infections during the 12 months preceding February 1.

Is Mr. Black eligible for STD benefits for his Period of Disability due to sinus surgery?

Our Decision and Rationale: No.

The policy states on page 13 that benefits will not be paid for a Disability that begins in the first 12 months after your coverage is in effect if that Disability was caused by, or related to, a condition for which you received medical treatment, took prescribed drugs, or consulted a Physician — whether in person, by phone, or by any other means — in the 12 months before your coverage became effective.

Because a sinus infection (for which Mr. Black was treated in the 12 months before his coverage took effect) is a condition related to sinus surgery (the condition that caused his Disability in the first 12 months of his coverage), STD benefits are not payable.

Example 2

- The ABC School District decides to change Short Term Disability (STD) insurance carriers, and we become the new carrier as of January 1.
- Mr. Smith, a teacher in the ABC School District, has been covered under the previous STD policy since 1962. He immediately signs up for coverage under this policy during the open enrollment period.
- On May 1, he has back surgery and submits a claim for STD benefits.
- Because his coverage has been in effect only four months, we review medical and other records to determine whether he is eligible for benefits. Upon reviewing records, we find that Mr. Smith has been treated on a monthly basis since 1996 for back pain.

Is Mr. Smith eligible for STD benefits for his Disability due to back surgery?

Our Decision and Rationale: Yes.

Although Mr. Smith has been covered by this policy for only four months and had been treated for back pain in the previous 12 months, he qualifies for the exception to the limitation on pre-existing conditions found on page 13. He was continuously covered by the previous STD policy and this policy for considerably longer than 12 months. In addition, because he was covered under the previous STD policy for many years, his claim would not have been barred by any pre-existing condition limitation in that plan. Therefore, he is entitled to benefits under this policy.

Examples of How We Apply the Definition of "Period of Disability" to Recurrent Disability

Read the definition of "Period of Disability" on page 4 and about how it pertains to recurrent Disability on page 11.

Example 1

- Mr. Jones is a bus driver who falls during a seizure and fractures his back. Because of the fracture, he is unable to perform his job duties. He fulfills his policy's Elimination Period and receives Short Term Disability (STD) benefits for 90 days of his 120-day Maximum Benefit Period.
- A month after he has been back to work, he begins to experience back pain. His Physician says that his fracture has not healed properly and that he will be restricted from performing his job duties for two more months to allow time for his back to completely heal.

Is Mr. Jones entitled to STD benefits during his second absence from work? If so, for how long?

Our Decision and Rationale: Yes.

Mr. Jones is entitled to a maximum of 30 more days of benefits during this second absence from work.

The second absence from work is considered the same Period of Disability as his first absence because:

1. He was back at work for less than six months, and
2. The second absence was due to the same cause as the first.

His Maximum Benefit Period for any one Period of Disability is 120 days. He has already used 90 days of benefits during his first absence from work. If he remains Disabled, he is eligible for the remaining 30 days of benefits during this second absence.

Example 2

- Now let's say that Mr. Jones, from Example 1 above, returns to work following his second absence. The back fracture he received during the seizure has completely healed.
- After two months back on the job, he experiences a series of seizures and is diagnosed with epilepsy. As a result, he is restricted from driving until his seizures have been adequately under control for a period of time.

Is Mr. Jones entitled to benefits this time?

Our Decision and Rationale: Yes.

He is entitled to another Maximum Benefit Period of 120 days of benefits.

Mr. Jones' two Disabilities were caused by different conditions. His first Period of Disability was due to the back fracture, and this Disability is due to the epilepsy. Therefore, they are two separate Periods of Disability even though they were not separated by six months.

Example 3

- Ms. Brown's Short Term Disability (STD) coverage has an Elimination Period of three days for Disabilities due to Sickness and a Maximum Benefit Period of 90 days.
- She has been experiencing numbness and tingling in her hands and arms. Her physician recommends bilateral carpal tunnel surgery.

- The first surgery is performed on September 15, and the second one is done a month later on October 15. She did not return to work between the two surgeries.
- Ms. Brown returns to active performance of her regular duties on February 1 of the following year.

When will her STD benefits begin and end?

Our Decision and Rationale: Ms. Brown's STD benefits will begin on September 18 and end on December 17.

Because her second surgery was performed before she had fully recovered from the first and returned to work, the entire length of time she was Disabled from the surgeries is considered one Period of Disability. Her benefits begin after the Elimination Period has been exhausted (**three days** after the September 15 surgery), **or** September 18. Benefits will end after the 90-day Maximum Benefit Period, **or** December 17.

Note that if Ms. Brown has WEA Long Term Disability (LTD) coverage, her Maximum Benefit Period of 90 days under this policy correlates with the 90-day Elimination Period that applies to her LTD coverage.

Example 4

Continuing with the circumstances involving Ms. Brown in Example 3 above:

- Ms. Brown returns to work on February 1 following her bilateral carpal tunnel surgery. She continues to experience numbness and tingling in her hands.
- Upon further evaluation, the Physician discovers that Ms. Brown has narrowing of the cervical spinal canal. This condition, and not carpal tunnel, was likely the cause of the numbness in her hands and arms from the beginning. Her Physician recommends a cervical laminectomy.

The cervical laminectomy is performed on March 1. Ms. Brown files another claim for Short Term Disability (STD) benefits. Her rationale is that her first Disability was due to carpal tunnel surgery and the second Disability is due to a cervical laminectomy.

Is Ms. Brown eligible for benefits for the cervical laminectomy?

Our Decision and Rationale: No.

We consider this successive Disability to be the same Period of Disability that began with her bilateral carpal tunnel surgeries because:

1. While this additional surgery was necessary to correct Ms. Brown's problems, both this surgery and the previous ones were related to the same set of symptoms and her two successive periods of Disability were due to the same or related cause, and
2. She did not return to work for at least six months between the surgeries.

Note, however, that if Ms. Brown is still covered under the WEA Long Term Disability (LTD) policy, she is eligible for LTD benefits immediately. Because the LTD policy also considers this one Period of Disability, she has already fulfilled the Elimination Period.

Examples of How We Apply the Waiver of Premium Provisions

Read about these provisions under “Waiver of Premium” and “What Happens if You Lose Coverage Due to Nonpayment of Premium” on page 2.

Example 1

- Mr. Anderson has been receiving benefits under this policy for 90 days, his Maximum Benefit Period, due to back surgery. He is now eligible for benefits under his Long Term Disability (LTD) policy with another insurance carrier.
- He calls to inform us that he has been found eligible for LTD benefits, and he submits a copy of the letter from the other insurer confirming approval of those LTD benefits. Therefore, we waive the premium for his coverage under this policy while he is eligible to receive LTD benefits, in accordance with the provisions under “Waiver of Premium.”
- Three months later, Mr. Anderson returns to work but fails to inform us or to resume paying premiums. Therefore, we don’t know he has returned to work, and we continue to waive his Short Term Disability (STD) premium.
- Three months after he returns to work, Mr. Anderson has an automobile accident and files an STD claim for his Disability due to the accident.

Is Mr. Anderson eligible for benefits under this policy as the result of his accident?

Our Decision and Rationale: No.

This policy requires Mr. Anderson to inform us when he is no longer receiving LTD benefits and to resume premium payments at that time. Because he did not inform us and resume paying premiums, his coverage under this policy ended on the date his LTD benefits ceased.

Example 2

Continuing with Mr. Anderson’s situation, as described above in Example 1:

- Mr. Anderson recovers from his automobile accident after three months and returns to work. He re-enrolls for coverage under this Short Term Disability (STD) policy.
- Because his re-enrollment is treated as a late enrollment, we require evidence of insurability that we consider acceptable before we will reinstate coverage. Mr. Anderson provides that evidence of insurability, and we approve his coverage effective October 1.
- He begins to develop problems with his right shoulder. His Physician determines these problems are a result of the accident and recommends surgery. On November 15, he undergoes surgery on his shoulder.

Is Mr. Anderson eligible for benefits for his Disability due to shoulder surgery?

Our Decision and Rationale: No.

The policy indicates that benefits will not be paid for a Disability that begins in the first 12 months that your re-enrollment coverage is in effect if that Disability was caused by, or related to, a condition for which you received medical treatment, took prescribed drugs, or consulted a Physician — whether in person, by phone, or by any other means — in the 12 months before your re-enrollment became effective. Because Mr. Anderson was treated, during the year before he re-enrolled, for a number of conditions related to his accident, he is not eligible for benefits.