AMENDMENT NO. 5 (Revised)

TO BE ATTACHED TO AND MADE PART OF GROUP POLICY NO.: 000010207849

ISSUED TO: ARUP Laboratories, Inc.

It is agreed that the above policy be replaced with the attached Policy, which is revised and dated January 1, 2019.

The effective date of this amendment is January 1, 2019; but only with respect to losses incurred on or after that date. Nothing contained in this amendment shall change any of the terms and conditions of this Policy; except as stated above.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Officer of the Company

Accepted by the Group Policyholder this _____ day of _____ 20_____

By _____ Title _____

The Lincoln National Life Insurance Company
A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: 8801 Indian Hills Drive, Omaha, NE 68114-4066
(800) 423-2765 Online: www.LincolnFinancial.com

Group Policyholder:

ARUP Laboratories, Inc.

In Consideration of the Group Policyholder's application for this Policy and payment of all premiums when due, The Lincoln National Life Insurance Company agrees to make the payments provided in this Policy to the persons entitled to them.

The first premium for this Policy is due on its effective date. Subsequent premiums are due on February 1, 2016, and on the same day of each month after that. Policy anniversaries will be each January 1st; unless shown otherwise on the Premium Rate Schedule inside.

The provisions and conditions set forth on the following pages are a part of this Policy, as fully as if recited over the signatures below.

The Lincoln National Life Insurance Company has executed this Policy at its Group Insurance Service Office in Omaha, Nebraska. The issue date of this Policy is January 1, 2016.

SECRETARY PRESIDENT

GROUP INSURANCE POLICY
No. 000010207849
PROVIDING
WEEKLY DISABILITY INCOME INSURANCE

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ARUP Laboratories, Inc.
000010207849
SCHEDULE OF INSURANCE

ELIGIBLE CLASS

Class 1 All Full-Time Employees

This Policy does not replace or provide benefits required by Workers' Compensation laws or any state disability insurance plan laws.

ARUP Laboratories, Inc.
000010207849
SCHEDULE OF INSURANCE
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: At least an average of 20 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
30 days of continuous Active Work

CONTRIBUTIONS: Insured Employees are required to contribute to the cost of the Weekly Disability Income Insurance.

WEEKLY DISABILITY INCOME INSURANCE

BENEFIT PERCENTAGE: 60%

MAXIMUM WEEKLY BENEFIT: $2,500

MINIMUM WEEKLY BENEFIT: 10% of the Weekly Total Disability Benefit

DAY BENEFITS BEGIN: 1st day of Hospitalization;
7th consecutive day of Disability due to Accidental Injury; and
7th consecutive day of Disability due to Sickness.

The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination thereof.

MAXIMUM BENEFIT PERIOD: 13 weeks

The Maximum Weekly Benefit will not exceed the Benefit Percentage times Basic Weekly Earnings.

Weekly Disability Income Insurance will terminate when an Insured Person retires.

ADDITIONAL FEATURES:

Family Income Benefit: 3 times the Insured Person's last Weekly Benefit payable immediately prior to death.

Rehabilitation Assistance Benefit:
- Rehabilitation Incentive Benefit of 5% of Basic Weekly Earnings
- Reasonable Accommodation Benefit
- Vocational Rehabilitation Benefit

DEFINITIONS

As used throughout this Policy, the following terms shall have the meanings indicated below. Other parts of this Policy contain definitions specific to those provisions.

ACTIVE WORK or **ACTIVELY AT WORK** means an Employee's performance of all Main Duties of his or her Own Occupation, for the regularly scheduled number of hours, at:

(1) the Employer's place of business; or
(2) any other business location where the Employer requires the Employee to travel.

Unless disabled on the prior workday or on the day of absence, an Employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday that is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) a non-medical leave of absence of 12 weeks or less, whether taken with the Employer's prior approval or on an emergency basis.

This includes a Military Leave or an approved Family or Medical Leave that is not due to the Employee's own health condition.

BASIC WEEKLY EARNINGS or **PREDISABILITY INCOME** means the Insured Person's average weekly base salary or hourly pay from the Employer before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the date the Disability begins.

It also includes:

(1) paid commissions averaged over the 12 months just prior to the Determination Date; or over the actual period of employment with the Employer just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Employer. It will not exceed the amount shown in the Employer's financial records, the amount for which premium has been paid, or the Maximum Covered Weekly Earnings permitted by this Policy; whichever is less. (Maximum Covered Weekly Earnings equals the Maximum Weekly Benefit divided by the Benefit Percentage shown in the Schedule of Insurance.) Exception: For purposes of determining the Partial Disability Weekly Benefit, Basic Weekly Earnings will not exceed the amount shown in the Employer's financial records.

COMPANY means The Lincoln National Life Insurance Company, an Indiana corporation. Its Group Insurance Service Office address is 8801 Indian Hills Drive, Omaha, Nebraska 68114-4066.

DAY or **DATE** means the period of time that begins at 12:01 a.m. and ends at 12:00 midnight, standard time, at the Group Policyholder's place of business. When used with regard to effective dates, it means 12:01 a.m. When used with regard to termination dates, it means 12:00 midnight.

DISABILITY or DISABLED means Total Disability or Partial Disability.

DISABILITY BENEFIT, when used with the term Retirement Plan, means a benefit that:

(1) is payable under a Retirement Plan due to disability as defined in that plan; and
(2) does not reduce the benefits that would have been paid as Retirement Benefits at the normal retirement age under the plan if the disability had not occurred.

If the payment of the benefit does cause such a reduction, the benefit will be deemed a Retirement Benefit as defined in this Policy.

EMPLOYEE or FULL-TIME EMPLOYEE means a person:

(1) whose employment with the Employer is the person's main occupation;
(2) whose employment is for regular wage or salary**,** on a full-time basis;
(3) who is regularly scheduled to work at such occupation at least the Minimum Hours shown in the Schedule of Insurance;
(4) who is a member of an Eligible Class which is eligible for coverage under this Policy;
(5) who is not a temporary or seasonal employee; and
(6) who is a citizen of the United States or legally works in the United States.

EMPLOYER means the Group Policyholder. It includes any division, subsidiary or affiliated company named in the Application or Participation Agreement.

EVIDENCE OF INSURABILITY means a statement of proof of an Employee's medical history. The Company uses this to determine his or her acceptance for insurance or an increased amount of insurance. Such proof will be provided at the Employee's own expense.

FAMILY OR MEDICAL LEAVE means an approved leave of absence that:

(1) is subject to the federal FMLA law (the Family and Medical Leave Act of 1993 and any amendments to it) or a similar state law;
(2) is taken in accord with the Employer's leave policy and the law which applies; and
(3) does not exceed the period approved by the Employer and required by that law.

Under the federal FMLA law, such leaves are permitted for up to 12 weeks in a 12-month period as defined by the Employer. The 12 weeks:

(1) may consist of consecutive or intermittent work days; or
(2) may be granted on a part-time equivalency basis.

If an Employee is entitled to a leave under both the federal FMLA law and a similar state law, he or she may elect the more favorable leave (but not both). If an Employee is on an FMLA leave due to his or her own health condition on the date Policy coverage takes effect, he or she is not considered Actively at Work.

FULL-TIME, as it applies to the Partial Disability Benefit, means the average number of hours the Insured Person was regularly scheduled to work, at his or her Own Occupation, during the week just prior to:

(1) the date Disability begins; or
(2) the date an approved leave of absence begins, if Disability begins while the Insured Person is continuing coverage during a leave of absence.

GROUP POLICYHOLDER means the person, company, trust or other organization as shown on the Title Page of this Policy.

INJURY means bodily Injury which results directly from an accident, independently of all other causes. In determining Weekly Benefits, a Disability will be considered caused by a Sickness if:

(1) the Disability begins more than 60 days after the Injury; or
(2) the Injury occurred before the Insured Person's Effective Date under this Policy.

The term "Injury" shall not include any:

(1) condition to which a Sickness, its natural progression or its treatment is a substantial contributing cause (based upon the preponderance of medical evidence);
(2) condition caused by emotional stress or trauma; infection (except pyogenic bacterial infection of an Injury); or medical or surgical treatment (except when needed solely for an Injury);
(3) repetitive trauma condition which results from repetitious, physically traumatic activities that occur over time; or
(4) pregnancy; except for complications that result from an Injury.

INSURANCE MONTH or **POLICY MONTH** means that period of time:
(1) beginning at 12:01 a.m. Standard Time, at the Group Policyholder's place of business on the first day of any calendar month; and
(2) ending at 12:00 midnight on the last day of the same calendar month.

INSURED PERSON means a Person for whom Policy coverage is in effect.

MAIN DUTIES or **MATERIAL AND SUBSTANTIAL DUTIES** means those job tasks that:
(1) are normally required to perform the Insured Person's Own Occupation; and
(2) could not reasonably be modified or omitted.

To determine whether a job task could reasonably be modified or omitted, the Company will apply the Americans with Disabilities Act's standards concerning reasonable accommodation. It will apply the Act's standards, whether or not:
(1) the Employer is subject to the Act; or
(2) the Insured Person has requested such a job accommodation.

An Employer's failure to modify or omit other job tasks does **not** render the Insured Person unable to perform the Main Duties of the job.

Main Duties include those job tasks:
(1) as described in the U.S. Department of Labor Dictionary of Occupational Titles; and
(2) as performed in the general labor market and national economy.

Main Duties are **not** limited to those specific job tasks as performed for a certain firm or at a certain work site.

MEDICALLY APPROPRIATE TREATMENT means diagnostic services, consultation, care or services that are consistent with the symptoms or diagnosis causing the Insured Person's Disability. Such treatment must be rendered:
(1) by a Physician whose license and any specialty are consistent with the disabling condition; and
(2) according to generally accepted, professionally recognized standards of medical practice.

MILITARY LEAVE means a leave of absence that:
(1) is subject to the federal USERRA law (the Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it);
(2) is taken in accord with the Employer's leave policy and the federal USERRA law; and
(3) does not exceed the period required by that law.

OWN OCCUPATION or **REGULAR OCCUPATION** means the occupation, trade or profession:
(1) in which the Insured Person was employed with the Employer prior to Disability; and
(2) which was his or her main source of earned income prior to Disability.

It means a collective description of related jobs, as defined by the U.S. Department of Labor Dictionary of Occupational Titles. It includes any work in the same occupation for pay or profit, regardless of:
(1) whether such work is with the Employer, with some other firm, or on a self-employed basis; or
(2) whether a suitable opening is currently available with the Employer or in the local labor market.

PARTIAL DISABILITY or **PARTIALLY DISABLED** means that, due to an Injury or Sickness, the Insured Person:
(1) is unable to perform one or more of the Main Duties of his or her Own Occupation, or is unable to perform such duties Full-Time; and
(2) is engaged in Partial Disability Employment.

PARTIAL DISABILITY EMPLOYMENT means the Insured Person is working at his or her Own Occupation or any other occupation; however, because of a Partial Disability:

(1) the Insured Person's hours or production is reduced;
(2) one or more Main Duties of the job are reassigned; or
(3) the Insured Person is working in a lower-paid occupation.

During Partial Disability Employment, his or her current earnings:

(1) must be at least 20% of Predisability Income; and
(2) may not exceed the percentage specified in the Partial Disability Benefit section.

PERSON means an Employee of the Employer:

(1) who is a member of an Employee class which is eligible for coverage under this Policy; and
(2) who has completed an enrollment form.

PERSONAL INSURANCE means the insurance provided by this Policy on Insured Persons.

PHYSICIAN means:

(1) a legally qualified medical doctor who is licensed to practice medicine, to prescribe and administer drugs, or to perform surgery; or
(2) any other duly licensed medical practitioner who is deemed by state law to be the same as a legally qualified medical doctor.

The medical doctor or other medical practitioner must be acting within the scope of his or her license. He or she must be qualified to provide Medically Appropriate Treatment for the Insured Person's disabling condition.

Physician does **not** include the Insured Person or a relative of the Insured Person receiving treatment. Relatives include:

(1) the Insured Person's spouse, siblings, parents, children and grandparents; and
(2) his or her spouse's relatives of like degree.

POLICY means this group insurance Policy issued by the Company to the Group Policyholder.

PREDISABILITY INCOME--See Basic Weekly Earnings definition.

REGULAR CARE OF A PHYSICIAN means the Insured Person:

(1) personally visits a Physician, as often as medically required according to standard medical practice to effectively manage and treat his or her disabling condition; and
(2) receives Medically Appropriate Treatment, by a Physician whose license and any specialty are consistent with the disabling condition.

REGULAR OCCUPATION--See Own Occupation or Regular Occupation definition.

RETIREMENT BENEFIT, when used with the term Retirement Plan, means a benefit that:

(1) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
(2) does not represent contributions made by an Insured Person (Payments representing Employee contributions are deemed to be received over the Insured Person's expected remaining life, regardless of when they are actually received.); and
(3) is payable upon:
    (a) early or normal retirement; or
    (b) disability (if the payment does reduce the benefit which would have been paid at the normal retirement age under the plan, if disability had not occurred).

RETIREMENT PLAN means a defined benefit or defined contribution plan that:
(1) provides Retirement Benefits to Employees; and
(2) is not funded wholly by Employee contributions.

The term shall **not** include any 401(k), profit-sharing or thrift plan; informal salary continuance plan; individual retirement account (IRA); tax sheltered annuity (TSA); stock ownership plan; or a non-qualified plan of deferred compensation.

An Employer's Retirement Plan is deemed to include any Retirement Plan:
(1) which is part of any federal, state, county, municipal or association retirement system; and
(2) for which the Insured Person is eligible as a result of employment with the Employer.

SICK LEAVE or **SALARY CONTINUANCE PLAN** means a plan that:
(1) is established and maintained by the Employer for the benefit of Employees; and
(2) continues payment of all or part of an Insured Person's Predisability Income for a specified period after he or she becomes Disabled.

It does **not** include compensation the Employer pays an Insured Person for work actually performed during a Disability.

SICKNESS means illness, pregnancy or disease.

TOTAL DISABILITY or **TOTALLY DISABLED** means the Insured Person's inability, due to Sickness or Injury, to perform each of the Main Duties of his or her Own Occupation. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does **not**, by itself, constitute Total Disability.

WAITING PERIOD means the period of time an Employee must be employed in an eligible class with the Employer, before he or she becomes eligible to enroll for coverage under this Policy. The period of service must be continuous, except as explained in the Eligibility provision captioned Prior Service Credit Towards Waiting Period.

WEEKLY BENEFIT means the amount payable weekly by the Company to the Insured Person who is Totally Disabled or Partially Disabled.

WORKERS' COMPENSATION OR SIMILAR COVERAGE means coverage under a law that compensates for job related Injury or Sickness. It includes (but is not limited to):
(1) coverage under any Workers' Compensation or occupational disease law;
(2) coverage under the Jones Act; the Longshoreman's and Harbor Worker's Act; the Maritime Doctrine of Maintenance, Wages or Cure; or
(3) any plan provided in place of one of those plans.

GENERAL PROVISIONS

ENTIRE CONTRACT. The entire contract between the parties shall consist of:
(1) this Policy and any amendments to it;
(2) the Group Policyholder's application (a copy of which is attached);
(3) any Participating Employers' applications or Participation Agreements; and
(4) any individual applications of Insured Persons.

In the absence of fraud, all statements made by the Group Policyholder and by Insured Persons are representations and not warranties. No statement made by an Insured Person will be used to contest the coverage provided by this Policy, unless:
(1) it is contained in a written statement signed by that Insured Person; and
(2) a copy of the statement has been furnished to that Insured Person.

AUTHORITY TO MAKE OR AMEND CONTRACT. Only a Company Officer located in the Company's Group Insurance Service Office has the authority to:
(1) determine the insurability of a group or any individual within a group;
(2) make a contract in the Company's name;
(3) amend or waive any provision of this Policy; or
(4) extend the time for payment of any premium.
No change in this Policy will be valid, unless it is made in writing and signed by such a Company Officer.

INCONTESTABILITY. Except for the non-payment of premiums or fraud, the Company may not contest the validity of this Policy after it has been in force for two years from its date of issue; and as to any Insured Person, after his or her coverage has been in force for two years during his or her lifetime. This clause does not preclude, at any time, the assertion of defenses based upon:
(1) this Policy's eligibility requirements, exclusions and limitations; and
(2) other Policy provisions unrelated to the validity of coverage.

RESCISSION. The Company has the right to rescind any insurance for which Evidence of Insurability was required, if:
(1) an Insured Person incurs a claim during the first two years of coverage; and
(2) the Company discovers that the Insured Person made a Material Misrepresentation on his or her application.

A **"Material Misrepresentation"** is an incomplete or untrue statement that caused the Company to issue coverage that it would have disapproved, had it known the truth. **"To rescind"** means to cancel insurance back to its effective date. In that event, the Company will refund all premium paid for the rescinded insurance, less any benefits paid for Insured Person's claims. The Company reserves the right to recover any claims paid in excess of such premiums.

NONPARTICIPATION. This is a non-participating Policy. It will not share in the divisible surplus of the Company.

INFORMATION TO BE FURNISHED. The Group Policyholder and any Participating Employers may be required to furnish any information needed to administer this Policy, including:
(1) information about Persons:
  (a) who become eligible for insurance;
  (b) whose amounts of coverage change; or
  (c) whose eligibility or coverage ends;
(2) occupational information and other facts that may be needed to manage a claim; and
(3) any other information that the Company may reasonably require.
The Company may inspect the Group Policyholder's or any Participating Employer's records that relate to this Policy, at any reasonable time.

Clerical error by the Group Policyholder or Participating Employer:
(1) will not void or terminate insurance that otherwise would be in effect;
(2) will not result in insurance coverage that otherwise would not be in effect; and
(3) will not continue insurance that otherwise would be terminated.

Once an error is discovered, a fair adjustment in premium will be made. If a premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period that precedes the date the Company receives proof such an adjustment should be made.

MISSTATEMENTS OF FACTS. If relevant facts about any Person were misstated:
(1) a fair adjustment of the premium will be made; and
(2) the true facts will decide if and in what amount insurance is valid under this Policy.

If an Insured Person's age has been misstated, any benefits shall be in the amount the paid premium would have purchased at the correct age.

ACTS OF THE POLICYHOLDER. In administering this Policy, the Group Policyholder must:
(1) treat Employees the same in like situations; and
(2) allow the Company, without inquiry, to rely on its acts.

GROUP POLICYHOLDER'S AGENCY. For all purposes of this Policy, the Group Policyholder acts on its own behalf or as an agent of the Insured Person. Under no circumstances will the Group Policyholder be deemed the agent of the Company.

CERTIFICATES. The Group Policyholder will be furnished with individual Certificates for delivery to each Insured Person. These certificates summarize the benefits provided by this Policy. If there is a conflict between this Policy and the Certificate, this Policy will control.

CONFORMITY WITH STATE STATUTES. If, on its effective date, any provision of this Policy conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

CURRENCY. In administering this Policy:
(1) all Predisability Income will be expressed in U.S. dollars; and
(2) all premium and benefit amounts must be paid in U.S. dollars.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE. This Policy does not replace or provide benefits required by:
(1) Workers' Compensation laws; or
(2) any state temporary disability insurance plan laws.

ASSIGNMENT. The rights and benefits under this Policy may not be assigned.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBLE CLASSES. The classes of Employees eligible for insurance are shown in the Schedule of Insurance. The Company has the right to review and terminate any or all classes eligible under this Policy, if any class ceases to be covered by this Policy.

ELIGIBILITY. A Person becomes eligible for coverage provided by this Policy on the later of:
(1) this Policy's date of issue; or
(2) the date the Waiting Period is completed.

Prior Service Credit Towards Waiting Period. The Waiting Period is shown in the Schedule of Insurance. Prior service in an Eligible Class will apply toward the Waiting Period, when:
(1) a former Employee is rehired within one year after his or her employment ends; or
(2) an Employee returns from an approved Family or Medical Leave within:
    (a) the 12-week leave period required by federal law; or
    (b) any longer period required by a similar state law; or
(3) an Employee returns from a Military Leave within the period required by federal USERRA law.

EFFECTIVE DATE. A Person's initial amount of Personal Insurance becomes effective at 12:01 a.m. on the latest of:
(1) the first day of the Insurance Month following the date the Person becomes eligible for the coverage;
(2) the date the Person resumes Active Work, if not Actively at Work on the day he or she becomes eligible;
(3) the date the Person makes written application for coverage and signs:
    (a) a payroll deduction order, if the Insured Person pays any part of this Policy's premiums; or
    (b) an order to pay premiums from the Person's Flexible Benefits Plan account, if Employer contributions are made through such an account; or
(4) the date the Company approves the Person's Evidence of Insurability, if required.

Any increased or additional coverage becomes effective at 12:01 a.m. on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase, if Actively at Work on that day;
(2) the date the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the date any required Evidence of Insurability is approved by the Company.

Any decrease will take effect on the day of the change, whether or not the Insured Person is Actively at Work.

Evidence of Insurability. Evidence of Insurability satisfactory to the Company must be submitted (at the Employee's expense) when:
(1) a Person makes written application for coverage (or an increased amount of coverage) more than 31 days after becoming eligible for the coverage; or
(2) a Person makes written application for coverage after he or she has requested:
    (a) to cancel insurance;
    (b) to stop payroll deductions for the insurance; or
    (c) to stop premium payments from the Flexible Benefits Plan account.

Effective Date for Change in Eligible Class. An Insured Person may become a member of a different Eligible Class. Coverage under the different Eligible Class will be effective:
(1) on the first day of the Insurance Month coinciding with or next following the date of the change;
(2) except as stated in the Effective Date provision for increases or decreases.

REINSTATEMENT RIGHTS. If an Insured Person's coverage terminates due to one of the following breaks in service, he or she will be entitled to reinstate the coverage upon resuming Active Work with the Employer within the required timeframe. **"Reinstatement"** or **"to reinstate"** means to re-enroll for this Policy's coverage, without satisfying a new Waiting Period or providing Evidence of Insurability. Reinstatement is available upon:

(1) return from an approved Family or Medical Leave within:
  (a) the 12-week period required by federal law; or
  (b) any longer period required by a similar state law;
(2) return from a Military Leave within the period required by federal USERRA law;
(3) return from any other approved leave of absence within six months after the leave begins;
(4) return within 12 months following a lay off; or
(5) return within 12 months following termination of employment for any other reason.

To reinstate coverage, the Insured Person must apply for coverage or be re-enrolled within 31 days after resuming Active Work in an Eligible Class. The reinstated amount of insurance may not exceed the amount that terminated. Reinstatement will take effect on the date the Insured Person returns to Active Work.

INDIVIDUAL TERMINATIONS

TERMINATION OF COVERAGE. An Insured Person's coverage will terminate at 12:00 midnight on the earliest of:

(1) the date this Policy terminates or the Employer's participation terminates (but without prejudice to any claim incurred prior to termination);
(2) the date the Insured Person's Class is no longer eligible for insurance;
(3) the date the Insured Person ceases to be a member of an Eligible Class;
(4) the last day of the Insurance Month in which the Insured Person requests termination;
(5) the last day of the last Insurance Month for which premium payment is made on the Insured Person's behalf;
(6) the end of the period for which the last required premium has been paid;
(7) with respect to any particular insurance benefit, the date the portion of this Policy providing that benefit terminates;
(8) the date the Insured Person's employment with the Group Policyholder or Participating Employer terminates (unless coverage is continued as provided below); or
(9) the date the Insured Person enters the armed services of any state or country on active duty, except for duty of 30 days or less for training in the Reserves or National Guard. (If the Insured Person sends proof of military service, the Company will refund any unearned premium).

CONTINUATION RIGHTS. Ceasing Active Work results in termination of the Insured Person's eligibility for coverage, but coverage may be continued as follows.

Disability. If the Insured Person is absent due to Total Disability or engaged in Partial Disability Employment, coverage may be continued:

(1) until the Day Benefits Begin; and
(2) during the period for which benefits are payable.

The Company must receive the required premium from the Employer.

Family or Medical Leave. If an Insured Person goes on an approved Family or Medical Leave and is **not** entitled to the more favorable continuation available during Disability, coverage may be continued until the earliest of:

(1) the end of the leave period approved by the Employer;
(2) the end of the leave period required by federal law, or any more favorable period required by a similar state law;
(3) the date the Insured Person notifies the Employer that he or she will not return; or
(4) the date the Insured Person begins employment with another employer.

The required premium payments must be received from the Employer, throughout the period of continued coverage.

Military Leave. If an Insured Person goes on a Military Leave, coverage may be continued for the same period allowed for an approved Family or Medical Leave. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Lay Off. When an Insured Person ceases work due to a temporary lay off, coverage may be continued for three Insurance Months after the lay off begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Other Leave. When an Insured Person ceases work due to an approved leave of absence (other than an approved Family or Medical Leave or a Military Leave); coverage may be continued for six Insurance Months after the leave begins. The required premium payments must be received from the Employer, throughout the period of continued coverage.

Conditions. In administering the above continuations, the Employer must not act so as to discriminate unfairly among Insured Persons in similar situations. Insurance may **not** be continued when an Insured Person ceases Active Work due to a labor dispute, strike, work slowdown or lockout.

INDIVIDUAL TERMINATION DURING DISABILITY. Termination of an Insured Person's coverage during a Disability will have no effect on benefits payable for that period of Disability.

PREMIUMS AND PREMIUM RATES

PAYMENT OF PREMIUMS. No coverage provided by this Policy will be in effect until the first premium for such coverage is paid. For coverage to remain in effect, each subsequent premium must be paid on or before its due date. The Group Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at the Company's Group Insurance Service Office. The premium must be paid in U.S. dollars.

PREMIUM RATE CHANGE. The Company may change any premium rate on any of the following dates:

(1) the date this Policy's terms are changed;
(2) the date the Company's liability is changed due to a change in federal, state or local law;
(3) the date the Company's liability is changed because the Group Policyholder (or any covered division, subsidiary or affiliated company):
    (a) relocates, dissolves or merges, or is added to or removed from this Policy; or
    (b) ceases to be covered by the state Worker's compensation program or any other program of like intent; or
    (c) ceases to provide or reduces Sick Leave or Salary Continuance Plan benefits;
(4) the date any coverage for one or more classes ceases to be provided under this Policy;
(5) the date the number of Insured Persons changes by 25% or more from the enrollment on the date this Policy took effect, or the most recent Rate Guarantee Date expired, if later; or
(6) on any premium due date on or after this Policy's first anniversary, or any later rate guarantee date agreed upon by the Company.

Unless the Company and the Group Policyholder agree otherwise, the Company will give at least 45 days' advance written notice of any increase in premium rates.

PREMIUM AMOUNT. The amount of premium due on each due date will be the sum of the products obtained by multiplying each rate shown in the Premium Rate Schedule by the amount of insurance to which the rate applies.

Premium adjustments will not be pro-rated daily. Instead, premium will be adjusted as follows.

(1) When an Insured Person's insurance or increase takes effect, premium will be charged from the monthly due date coinciding with or next following that change.
(2) When all or part of an Insured Person's insurance terminates, the applicable premium will cease on the monthly due date coinciding with or next following that termination.
(3) When premiums are paid other than monthly, increases or decreases will result in adjustment from the premium due date coinciding with or next following that change.

The above manner of charging premium is for accounting purposes only. It will not extend coverage beyond a date it would have otherwise terminated. Each premium payment will include any adjustments in past premiums, which are needed due to changes that have not yet been taken into account. If a premium adjustment involves a return of unearned premium, the refund will be limited to the prior 12-month period.

PREMIUM RATE SCHEDULE

Monthly Weekly Disability Income Rate	$.335	per $10 of weekly benefit

The above rate or rates are guaranteed until January 1, 2019, unless an exception listed in the Premium Rate Change section applies. After that, any premium rate change will be as shown in the renewal letter. The Company will send the Group Policyholder a renewal letter prior to each Policy Anniversary.

GRACE PERIOD

A grace period of 60 days from the due date will be allowed for the payment of each premium after the first. This Policy will remain in effect during the grace period; unless the Group Policyholder gives the Company advance written notice of termination. The Group Policyholder will remain liable for payment of a pro rata premium for the time this Policy remained in force during the grace period.

POLICY TERMINATION

TERMINATION BY THE COMPANY. To terminate this Policy, the Company must give the Group Policyholder at least 31 days' advance written notice of its intent to do so. The Company may terminate this Policy coverage on the due date of any premium; if:

(1) the total number of Insured Persons is less than ten;
(2) all of the premium is paid by the Group Policyholder and less than 100% of those eligible for coverage are insured;
(3) part of the premium is paid by Insured Persons and less than 100% of those eligible for coverage are insured;
(4) the Group Policyholder, without good cause, fails to:
    (a) promptly furnish any information the Company reasonably requires; or
    (b) perform its duties pertaining to this Policy in good faith;
(5) the Company terminates all other policies where permitted by their terms, which provide life insurance or weekly disability income insurance in the same state in which this Policy was issued; or
(6) state law otherwise requires this Policy to be terminated.

TERMINATION BY GROUP POLICYHOLDER. The Group Policyholder may terminate this Policy at any time, by giving the Company advance written notice. Coverage will then terminate:

(1) on the date the Company receives the notice; or
(2) any later date the Group Policyholder and the Company have agreed upon.

The Group Policyholder remains responsible for the payment of premiums to the date of termination. The Group Policyholder must give 30 days' prior written notice of termination, along with information on any continuation rights, to each Insured Person.

AUTOMATIC TERMINATION. If any premium remains unpaid at the end of the Grace Period; then this Policy will automatically terminate, without any action on the Company's part, on the last day of the Grace Period. The Group Policyholder remains responsible for the payment of premiums to the date of termination.

EFFECT ON INCURRED CLAIMS. Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

CLAIMS PROCEDURES
FOR WEEKLY DISABILITY INCOME BENEFITS

NOTICE AND PROOF OF CLAIM -- Notice of Claim. Written notice of a Disability claim must be given:
(1) within 20 days after Disability begins; or
(2) as soon as reasonably possible after that.*
The notice should be sent by first class mail to the Company's Group Insurance Service Office. It should include the Insured Person's name and address and the number of this Policy.

Notice sent to any of the Company's authorized agents in Utah, with enough detail to identify this Policy, will also be deemed notice to the Company.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days, the Insured Person may send the Company written proof of Disability in a letter. It should state the date the Disability began, its cause and degree. The Company will periodically send the Insured Person additional claim forms.

Proof of Claim. The Company must be given written proof of a Disability claim:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.*

Proof of claim must be provided at the Insured Person's own expense. It must show the date the Disability began, its cause and degree. Documentation must include the following:
(1) completed statements by the Insured Person and the Employer;
(2) a completed statement by the attending Physician, which must describe any restrictions on the performance of the duties of the Insured Person's Regular Occupation;
(3) proof of any other income received, and of any other benefits available from other income sources, which may affect Policy benefits;
(4) a signed authorization for the Company to obtain more information; and
(5) any other items the Company may reasonably require in support of the claim.

Proof of continued Disability, Regular Care of a Physician, and any Other Income Benefits affecting the claim:
(1) should be given within 45 days after the Company requests it; and
(2) in any event, must be given by the 90th day after the Company's period of liability ends.
However the Insured Person's delay in giving further proof will not impair the right to benefits, which would otherwise accrue, during the six months prior to giving such proof.

*** Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim, if:
(1) the Insured Person shows that it was sent as soon as reasonably possible; or
(2) the Company fails to show that its position was prejudiced by the delay.

EXAMINATION. The Company may have the Insured Person examined:
(1) by a Physician, specialist or vocational rehabilitation expert of the Company's choice;
(2) as often as reasonably required while a claim or appeal is pending.

Any such exam will be at the Company's expense.

The Company may determine that (in its opinion) the Insured Person has:
(1) failed to cooperate with an examiner;
(2) failed to take an exam scheduled by the Company; or
(3) postponed such an exam more than twice.
In that event, benefits may be denied or suspended, until the required exam is completed.

TIME OF PAYMENT OF CLAIMS. Weekly Disability Income Benefits payable under this Policy will be paid within 15 days after the Company receives complete proof of claim and completes any further claim investigation it needs to confirm liability. Such benefits will be paid biweekly, during any period for which the Company is liable. If benefits are due for less than a week, they will be paid on a pro rata basis. The daily rate will equal 1/7 of the Weekly Benefit.

Any balance, which remains unpaid at the end of the period of liability, will be paid within 15 days after the Company receives complete proof of claim and completes any further claim investigation it needs to confirm liability.

INTEREST ON LATE CLAIMS. Any claim payment that is not made by the 15th day will accrue interest, at the rate of 10% per year.

TO WHOM PAYABLE. All Weekly Disability Income Benefits are payable to the Insured Person, while living. After the Insured Person's death, such benefits will be payable to his or her estate.

NOTICE OF CLAIM DECISION. The Company will send the Insured Person a written notice of its claim decision. If the Company denies any part of the claim, the written notice will explain:

(1) the reason for the denial, under the terms of this Policy and any internal guidelines;
(2) how the Insured Person may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after receiving complete proof of claim and completing any further claim investigation needed to resolve the claim. It will be sent within 45 days after the Company receives the first proof of claim, if reasonably possible.

Delay Notice. The Company may need more than 15 days to process the claim, due to matters beyond its control. If so, an extension will be permitted. If needed, the Company will begin its claim investigation by requesting any additional information needed from others, and will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances requiring the delay, including:

(1) what additional information is needed;
(2) whether any part of the claim is contested; and
(3) when a decision can be expected.

If the claimant does not receive a written decision by the 105th day after the Company receives the first proof of claim; then he or she has a right to an immediate review, as if the claim was denied.

Exception: The Company may need more information from the Insured Person to process a claim. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. Within 180 days after receiving a denial notice, the Insured Person may request a claim review by sending the Company:

(1) a written request; and
(2) any written comments or other items to support the claim.

The Company will begin any further claim investigation needed, and will send the Insured Person:

(1) a written acknowledgement, within 15 days after receiving the appeal; and
(2) a written delay notice every 30 days after that, until the appeal is decided.

He or she may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the Insured Person a written notice of its decision, within 15 days after completing any further claim investigation and deciding the appeal. The notice will state the reasons for the Company's decision, under the terms of this Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim, the notice will also describe:

(1) any further appeal procedures available under this Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

This notice will be sent within 45 days after the Company receives the request for review, or within 90 days if a special case requires more time.

Delay Notice. If the Company needs more than 45 days to process an appeal, in a special case:

(1) an extension of up to 45 more days will be permitted; and
(2) the Company will send the Insured Person a written delay notice, by the 30th day after receiving the request for review.

The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: The Company may need more information from the Insured Person to process an appeal. If so, it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

Claims Subject to ERISA (Employee Retirement Income Security Act of 1974**).** Before bringing a civil legal action under the federal labor law known as ERISA, an employee benefit plan participant or beneficiary must exhaust available administrative remedies. Under this Policy, the plan participant or beneficiary must first seek two administrative reviews of the adverse claim decision, in accord with this section. After the required reviews:

(1) an ERISA plan participant or beneficiary may bring legal action under Section 502(a) of ERISA; and
(2) the Company will waive any right to assert that he or she failed to exhaust administrative remedies.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim, full reimbursement to the Company is required. It must be made within 60 days after the Company sends written notice of the overpayment. If reimbursement is not made, the Company has the right to:

(1) reduce future benefits and suspend payment of the Minimum Weekly Benefit under this Policy, until full reimbursement is made;
(2) reduce benefits payable to the Insured Person under any group insurance policy issued by the Company, until full reimbursement is made; or
(3) recover such overpayments from the Insured Person or his or her estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, the Insured Person's receipt of other income benefits, or any other reason.

If benefits have been underpaid on any claim, full payment will be made within 15 days after the Company:

(1) discovers the error; or
(2) receives acceptable proof of the additional liability.

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S AUTHORITY TO ADMINISTER ERISA PLAN. Benefits under this Policy will be paid only if the Company decides in its discretion that the claimant is entitled to them. The Company also has discretion to determine eligibility for benefits and to interpret the terms and conditions of this Policy. Determinations made by the Company pursuant to this reservation of discretion do not prohibit or prevent the claimant from seeking judicial review in federal court of the Company's determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when the claimant seeks judicial review of the Company's determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to this Policy.

The Company is an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord the Company's determinations.
This provision does not apply to residents of California.

WEEKLY DISABILITY INCOME INSURANCE

TOTAL DISABILITY BENEFIT. The Company will pay a Weekly Total Disability Benefit for each week the Total Disability continues, if the Insured Person:

(1) becomes Totally Disabled while insured for this benefit;
(2) is under the Regular Care of a Physician; and
(3) at his or her own expense, submits proof of continued Total Disability and Physician's care to the Company upon request.

Duration. Benefits start on the Day Benefits Begin, and end on the earliest of:

(1) the date the Insured Person ceases to be Totally Disabled or dies;
(2) the date the Maximum Benefit Period ends; or
(3) the date the Insured Person is able, but chooses not to engage in Partial Disability Employment in his or her Own Occupation.

Proportional benefits will be paid for a partial week of Total Disability.

At the Company's option, benefits may also be denied or suspended on any of the following dates:

(1) the date the Insured Person (without good cause):
    (a) fails to take a required medical exam;
    (b) fails to cooperate with an examiner; or
    (c) postpones a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of the Insured Person's application for any Other Income Benefits to which he or she may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Total Disability Benefit equals the lesser of:

(1) the Insured Person's Basic Weekly Earnings multiplied by the Benefit Percentage; minus Other Income Benefits except any pay received under the Employer's Sick Leave or Salary Continuance Plan;
(2) 100% of the Insured Person's Basic Weekly Earnings; minus Other Income Benefits including any pay received under the Employer's Sick Leave or Salary Continuance Plan; or
(3) the Maximum Weekly Benefit.

In no event will the amount of the Weekly Total Disability Benefit plus any pay received under the Employer's Sick Leave or Salary Continuance Plan exceed 100% of the Insured Person's Basic Weekly Earnings.

The amount of the Weekly Total Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of the Insured Person's Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

PARTIAL DISABILITY BENEFIT. The Company will pay a Weekly Partial Disability Benefit, if the Insured Person:

(1) becomes Partially Disabled while insured for this benefit;
(2) is engaged in Partial Disability Employment;
(3) is earning at least 20% of Basic Weekly Earnings when Partial Disability Employment begins;
(4) is under the Regular Care of a Physician; and
(5) at his or her own expense, submits proof of continued Partial Disability, Physician's care and reduced earnings to the Company upon request.

The Insured Person is not required to be Totally Disabled prior to receiving Weekly Partial Disability Benefits. The Day Benefits Begin may be reached by days of Total Disability, Partial Disability, or any combination of these. Proportional benefits will be paid for a partial week of Partial Disability.

Duration. Benefits start on the Day Benefits Begin, and will cease on the earliest of:
(1) the date the Insured Person ceases to be Partially Disabled or dies;
(2) the date the Maximum Benefit Period ends;
(3) the date the Insured Person earns more than 99% of Basic Weekly Earnings; or
(4) the date the Insured Person is able, but chooses not to work Full-Time or part-time in his or her Own Occupation.

At the Company's option, benefits may also be denied or suspended on any of the following dates:
(1) the date the Insured Person (without good cause):
  (a) fails to take a required medical exam;
  (b) fails to cooperate with an examiner; or
  (c) postpones a required exam more than twice;
(2) the 45th day after the Company requests additional proof, if not given; or
(3) the 45th day after the Company requests proof of the Insured Person's application for Other Income Benefits to which he or she may be entitled (and which affect Policy benefits); if not given.

Amount. The amount of the Weekly Partial Disability Benefit equals the lesser of A or B below:
(A) (1) The Insured Person's Basic Weekly Earnings multiplied by the Benefit Percentage (limited to the Maximum Weekly Benefit); minus
  (2) Other Income Benefits, except for earnings the Insured Person receives from Partial Disability Employment; or
(B) The Insured Person's Basic Weekly Earnings minus Other Income Benefits.

The amount of the Weekly Partial Disability Benefit will not be less than the Minimum Weekly Benefit, unless the Minimum Weekly Benefit plus Other Income Benefits would exceed 100% of the Insured Person's Basic Weekly Earnings.

The Day Benefits Begin, Maximum Benefit Period, Benefit Percentage, Maximum Weekly Benefit, and Minimum Weekly Benefit are shown in the Schedule of Insurance.

OTHER INCOME BENEFITS means Earnings, benefits, awards, or settlements from the following sources. These amounts will be offset, in determining the Insured Person's Weekly Benefit. Except for Retirement Benefits and Earnings, these amounts must result from the same Disability for which a Weekly Benefit is payable under this Policy.

Compulsory Benefits. Any disability income benefits the Insured Person is eligible to receive under:
(1) state temporary disability income benefit laws;
(2) state no fault auto insurance laws; or
(3) any other compulsory benefit act or law (except Workers' Compensation and laws of like intent).

Other Insurance Plans. Any disability income benefits for which the Insured Person is eligible under any no fault auto plan.

Employee Benefit Plans. Any disability income benefits for which the Insured Person is eligible under the Employer's Sick Leave or Salary Continuance Plan. This does **not** include vacation pay, severance pay, or pay for work actually performed during a Disability.

Employer's Retirement Plan. Any Disability Benefits or Retirement Benefits the Insured Person receives under the Employer's Retirement Plan.

Social Security and other Government Retirement Plans. The following Social Security or other Government Retirement Plan benefits will be offset:
(1) **disability benefits** for which the Insured Person and any spouse or child is eligible, because of the Insured Person's Disability;
(2) **unreduced retirement benefits** for which the Insured Person and any spouse or child is eligible, because of the Insured Person's eligibility for unreduced retirement benefits; or
(3) **reduced retirement benefits** actually received by the Insured Person and any spouse or child, because of the Insured Person's receipt of reduced retirement benefits.

As used above, "**Government Retirement Plans"** include disability and retirement benefits under:
(1) the federal Social Security Act, Jones Act or Railroad Retirement Act;
(2) the Canada Pension Plan or Quebec Pension Plan;
(3) any similar plan or act of any country, state, province or other political unit; or
(4) any plan provided in place of one of the above plans.

"Earnings", as used in this provision, means pay the Insured Person earns or receives from any occupation or form of employment, as reported for federal income tax purposes. Earnings include (but are not limited to) a:
(1) salaried or hourly Employee's gross earnings (shown on Form W-2); including:
  (a) wages, tips, commissions, bonuses and overtime pay; and
  (b) any pre-tax contributions to a Section 125 Plan, flexible spending account, or qualified deferred compensation plan;
(2) proprietor's net profit (figured from Form 1040, Schedule C);
(3) professional corporation shareholder's net profit (figured from Form 1040, Schedule C);
(4) partner's net earnings from self-employment (shown on Schedule K-1) and any W-2 earnings; and
(5) Subchapter S Corporation shareholder's net earnings from trade or business activities (shown on Schedule K-1).

Recovery from Third Party. Any amount the Insured Person recovers from a third party as a result of the Disability (whether by judgment, settlement or otherwise). The offset:
(1) will be reduced by attorney fees and other reasonable costs of recovery; and
(2) will not exceed 100% of the net settlement.

Exceptions. The following will **not** be considered Other Income Benefits, and will not be offset in determining the Weekly Benefit:

(1) a cost-of-living increase in any Other Income Benefit (except Earnings); if it takes effect after the first offset for that benefit during a period of Disability;
(2) reimbursement for hospital, medical or surgical expense;
(3) reimbursement for attorney fees or other reasonable costs of claiming Other Income Benefits;
(4) group credit or mortgage disability insurance;
(5) early retirement benefits that are not elected or received under the federal Social Security Act or other Government Retirement Plan;
(6) any amounts under the Employer's Retirement Plan that:
    (a) represent the Insured Person's contributions; or
    (b) are received upon termination of employment without being disabled or retired;
(7) benefits from a 401(k), profit-sharing or thrift plan; an individual retirement account (IRA); a tax sheltered annuity (TSA); a stock ownership plan; or a non-qualified plan of deferred compensation;
(8) vacation pay, holiday pay, or severance pay; or
(9) disability income benefits under any individual policy, association group plan, franchise plan, or auto liability insurance policy (except no fault auto insurance).

RULES CONCERNING OTHER INCOME BENEFITS. If the Insured Person may be entitled to Other Income Benefits that affect Policy benefits, he or she is required to actively claim them. For example, if Social Security or other Government Retirement Plan benefits may be payable, the Insured Person:

(1) must promptly apply for such benefits; and, if denied
(2) must file an appeal or request an administrative hearing, upon Company request.

If the Insured Person fails to promptly pursue such benefits, the Company has the option to deny or suspend Weekly Benefits or to reduce them by an estimated amount.

If Workers' Compensation or similar benefits may be payable for the same Disability, the Insured Person and Employer are required to cooperate in filing for those benefits. The Company will require proof of the denial or duration of those benefits to confirm its liability under this Policy.

Refunding Overpayments. Upon receiving Other Income Benefits, the Insured Person must refund any resulting overpayment of Weekly Benefits under this Policy. If he or she does not promptly refund an overpayment to the Company within 60 days, in a lump sum, then:

(1) the Company will reduce or eliminate future payments; and
(2) the Minimum Weekly Benefit will not apply, until the amount is repaid.

Cost of Living Freeze. After the first deduction for each of the Other Income Benefits (except Earnings), its amount will be frozen. The Weekly Benefit will not be further reduced due to any cost-of-living increases payable under these Other Income Benefits.

RECURRENT DISABILITY. "Recurrent Disability" means a Disability caused by an Injury or Sickness which is the same as, or related to, the cause of a prior Disability for which Weekly Benefits were payable.

(1) A Recurrent Disability will be treated as a new period of Disability, if the Insured Person:
    (a) has returned to his or her Own Occupation; and
    (b) has worked on a full-time basis, for two consecutive weeks or more.
    A new Day Benefits Begin and new Maximum Benefit Period will apply.
(2) A Recurrent Disability will be treated as part of the prior Disability, if the Insured Person:
    (a) has returned to his or her Own Occupation; and
    (b) has worked on a full-time basis, for less than two consecutive weeks.
    The same Day Benefits Begin and same Maximum Benefit Period will apply to the Recurrent Disability as to the prior Disability.

To qualify for a Weekly Benefit for a Recurrent Disability, the Insured Person must earn less than the percentage of Predisability Income specified in the Partial Disability Benefit section. Benefit payments will be subject to all other terms of this Policy that applied to the prior Disability.

This Recurrent Disability provision will cease to apply to an Insured Person who becomes eligible for coverage under any other group short-term disability policy.

EXCLUSIONS. Weekly Benefits will not be payable for any period of Disability:

(1) which is the result of an intentionally self-inflicted Injury or suicide attempt;
(2) during which the Insured Person is not under the Regular Care of a Physician;
(3) which is the result of war (declared or undeclared) or any act of war;
(4) which is the result of a Sickness or Injury for which the Insured Person receives benefits under Workers' Compensation or similar coverage; or
(5) which arises out of (or in the course of) any employment for wage or profit, when the Disability would be covered by Workers' Compensation or similar coverage if:
    (a) the Employer had enrolled the Insured Person for such coverage; and
    (b) the Insured Person and Employer had cooperated in filing a claim under that plan.

VOCATIONAL REHABILITATION BENEFIT

BENEFIT. If an Insured Person is Disabled and is receiving Weekly Benefits under this Policy, he or she may be eligible for a Vocational Rehabilitation Benefit. This benefit consists of services which may include:

(1) vocational evaluation, counseling, training or job placement;
(2) job modification or special equipment; and
(3) other services which the Company deems reasonably necessary to help the Insured Person return to work.

The Company will determine the Insured Person's eligibility and the amount of any benefit payable.

ELIGIBILITY. An Insured Person may be eligible for the Vocational Rehabilitation Benefit if the Company finds that he or she:

(1) has a Disability that prevents the performance of the Main Duties of his or her Own Occupation;
(2) has the physical and mental abilities needed to complete a Rehabilitation Program; and
(3) is reasonably expected to return to work after completing the Rehabilitation Program; in view of his or her degree of motivation and the labor force demand for workers in the proposed occupation.

The Company must also find that the cost of the proposed services is less than its expected claim liability.

AMOUNT. The amount of any Vocational Rehabilitation Benefit will not exceed the Company's expected claims liability. This benefit will not be payable for services covered under the Insured Person's health care plan or any other vocational rehabilitation program. Payment may be made to the provider of the services, at the Company's option.

CONDITIONS. The Company, the Insured Person, or his or her Physician may first propose vocational rehabilitation. When a Rehabilitation Program is approved by the Company, this Policy's definition of "Disability" will be waived during the rehabilitation period; however, it will be reapplied after the Rehabilitation Program ends. The Company will determine the amount and duration of any Weekly Disability benefits payable after the Rehabilitation Program ends.

LIMITATION. This Policy will not cover any period of Disability for an Insured Person who has received a Vocational Rehabilitation Benefit and has failed to complete the Rehabilitation Program, without Good Cause.

DEFINITIONS.

"Good Cause," as used in this provision, means the Insured Person's:

(1) documented physical or mental impairments, which render the Insured Person unable to take part in or complete a Rehabilitation Program;
(2) involvement in a medical program, which prevents or interferes with the Insured Person's taking part in or completing a Rehabilitation Program; or
(3) participating in good faith in some other vocational rehabilitation program, which:
    (a) conflicts with taking part in or completing a Rehabilitation Program developed by the Company; and
    (b) is reasonably expected to return the Insured Person to work.

"Rehabilitation Program" means a written vocational rehabilitation program:

(1) which the Company develops with input from:
    (a) the Insured Person;
    (b) the Insured Person's Physician; and
    (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of this Policy.

REHABILITATION INCENTIVE BENEFIT

BENEFIT. The Company will pay a Rehabilitation Incentive Benefit to an Insured Person who is Totally or Partially Disabled and who actively participates in a Rehabilitation Program approved by the Company.

AMOUNT. The amount of the Rehabilitation Incentive Benefit is shown in the Schedule of Insurance.

The Rehabilitation Incentive Benefit is paid in addition to any other Policy benefits, and is not subject to Policy provisions that would otherwise reduce the benefit amount, such as the Other Income Benefits provision.

DURATION. The Rehabilitation Incentive Benefit starts on the latest of:
(1) the date the Insured Person begins to participate in an approved Rehabilitation Program; or
(2) the date the Company approves the Insured Person's Rehabilitation Program.

The Rehabilitation Incentive Benefit will cease on the earliest of:
(1) the date the Weekly Total or Partial Disability Benefits would otherwise cease under this Policy; or
(2) the date the Insured Person ceases participation in an approved Rehabilitation Program.

DEFINITION.

"Rehabilitation Program" means a written vocational rehabilitation program:
(1) which the Company develops with input from:
  (a) the Insured Person;
  (b) the Insured Person's Physician; and
  (c) any current or prospective employer, when appropriate; and
(2) which describes the Program's goals; each party's responsibilities; and the times, dates and costs of the rehabilitation services.

PROOF. Written proof of active participation in a Rehabilitation Program must be given:
(1) within 90 days after the Day Benefits Begin; or
(2) as soon as reasonably possible after that.

Proof of active participation must be provided at the Insured Person's own expense. The proof must be sent to the Company's Group Insurance Service Office. It should include the Insured Person's name and address and the number of this Policy.

Exception: Failure to furnish proof of active participation in a Rehabilitation Program within the required time period will not invalidate the benefit, if:
(1) the Insured Person shows that it was sent as soon as reasonably possible; or
(2) the Company fails to show that its position was prejudiced by the delay.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of this Policy.

REASONABLE ACCOMMODATION BENEFIT

BENEFIT. If an Insured Person is Disabled and is receiving Weekly Benefits under this Policy, then the Group Policyholder may be eligible for a Reasonable Accommodation benefit. This benefit reimburses the Group Policyholder for 50% of the expense incurred for reasonable accommodation services for the Insured Person, but will not exceed the lesser of:

(1) a maximum benefit of $2500 for any one Insured Person; or
(2) the Company's expected liability for the Insured Person's Weekly Disability Income claim.

Such services may include:

(1) providing the Insured Person a more accessible parking space or entrance;
(2) removing barriers or hazards to the Insured Person from the worksite;
(3) special seating, furniture or equipment for the Insured Person's work station;
(4) providing special training materials or translation services during the Insured Person's training; and
(5) other services the Company deems reasonably necessary to help the Insured Person return to work with the Group Policyholder.

ELIGIBILITY. The Company will determine the Group Policyholder's eligibility to receive the Reasonable Accommodation benefit. To qualify for the Reasonable Accommodation benefit, the Group Policyholder must have an Insured Person:

(1) whose Disability prevents the performance of his or her Own Occupation at the Group Policyholder's worksite;
(2) who has the physical and mental abilities needed to perform his or her Own Occupation or another occupation at the Group Policyholder's worksite, but only with the help of the proposed accommodation; and
(3) who is reasonably expected to return to work with the help of the proposed accommodation.

The Company must also find that the requested Reasonable Accommodation benefit is less than the expected liability for the Insured Person's Weekly Disability Income claim.

WRITTEN PROPOSAL. The reasonable accommodation services must be provided in accord with a written proposal, which is developed with input from:

(1) the Group Policyholder;
(2) the Insured Person; and
(3) the Insured Person's Physician, when appropriate.

The proposal must state:

(1) the purpose of the proposed accommodation; and
(2) the times, dates, and costs of the services.

CONDITIONS. The Company, the Group Policyholder, the Insured Person, or the Insured Person's Physician may first propose an accommodation.

The proposal must be approved by the Company in writing.

The Company will reimburse the Group Policyholder upon receipt of proof that the Group Policyholder:

(1) has provided the services for the Insured Person; and
(2) has paid the provider for the services.

OTHER PROVISIONS. Unless stated otherwise, the Reasonable Accommodation benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of this Policy.

FAMILY INCOME BENEFIT

BENEFIT. The Company will pay a benefit to the Eligible Survivor(s) when satisfactory written proof is received that an Insured Person died:

(1) after Disability had continued for at least 14 consecutive days; and
(2) while receiving a Weekly Benefit.

If payment becomes due to the Insured Person's children; then payment will be made to:

(1) the surviving children, in equal shares; or
(2) a person named by the Company to receive payments on the children's behalf.

This payment will be valid and effective against all claims by others representing, or claiming to represent, the Insured Person's children.

If there are no Eligible Survivors, payment will be made to the Insured Person's estate.

AMOUNT. The Family Income Benefit is shown in the Schedule of Insurance. Reductions for Other Income Benefits will not apply.

If any state disability plan compulsory death benefits become payable upon the Insured Person’s death, then any Family Income Benefit amount payable will be reduced by such compulsory death benefits.

DEFINITION.

"Eligible Survivor(s)" means the Insured Person's:

(1) surviving spouse or domestic partner; or, if none,
(2) surviving children who are under age 25 on the Insured Person's date of death.

OTHER PROVISIONS. Unless stated otherwise, this benefit is subject to all the Definitions, Exclusions, Claims Procedures, and other provisions of this Policy.

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

AMENDMENT TO BE ATTACHED TO AND MADE PART OF GROUP POLICY NO: 000010207849

ISSUED TO: ARUP Laboratories, Inc.

The Policy is amended by the addition of the following provisions.

PRIOR INSURANCE CREDIT UPON TRANSFER OF DISABILITY INCOME INSURANCE CARRIERS

This provision prevents loss of disability income coverage for an Insured Person, which could otherwise occur solely because of a transfer of insurance carriers. This Policy will provide the following Prior Insurance Credit, when it replaces a prior plan.

"Prior Plan" means a prior carrier's group disability income policy, which this Policy replaced within 1 day of the prior plan's termination date.

FAILURE TO SATISFY ACTIVE WORK RULE. Subject to premium payments, this Policy will provide disability income coverage to a Person who:

(1) was insured by the prior plan on its termination date; and
(2) was otherwise eligible under this Policy; but was not Actively-At-Work due to Injury or Sickness on its Effective Date.

AMOUNT OF COVERAGE. Until the Person satisfies this Policy's Active Work rule, his or her disability income coverage will not exceed that provided by the prior plan, had it remained in force. The Company will pay:

(1) the benefit the prior plan would have paid; minus
(2) any amount for which the prior carrier is liable.

This Amendment takes effect on the effective date of coverage under this Policy. In all other respects, this Policy remains the same.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY

Officer of the Company