

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

• **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

• **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

• **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

• **Life Insurance**

80% of death benefits but not to exceed \$300,000

80% of cash surrender or withdrawal values but not to exceed \$100,000

• **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

• **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
PO Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles CA 90013
(800) 927-4357

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

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy at:

**Standard Insurance Company
PO Box 711
Portland, OR 97207
(503) 321-7000**

If the problem is not resolved, you may also write to the State of California at:

**Department of Insurance
Consumer Services Division
300 S. Spring Street, 9th FL
Los Angeles, CA 90013
1-800-927-HELP (4357)**

www.insurance.ca.gov/0500-about-us/02-department/030-csmcb/consumer-services.cfm

This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.



STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE AND SUMMARY PLAN DESCRIPTION GROUP SHORT TERM DISABILITY INSURANCE

Policyholder:	Super Micro Computer, Inc.
Policy Number:	173093-B
Effective Date:	November 1, 2024

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer's coverage under the Group Policy. If the terms of this Certificate and Summary Plan Description differ from the terms of your Employer's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate and Summary Plan Description or other notice to be given to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section headings, and references to them, appear in boldface type.

President and CEO

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COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Deductible Income appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number: 173093-B
Policyholder: Super Micro Computer, Inc.
Employer(s): Super Micro Computer, Inc.
Group Policy Effective Date: November 1, 2024
Policy Issued in: California

Member means:

1. A regular employee of the Employer;
2. Actively At Work at least 30 hours each week (for purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days); and
3. A citizen or resident of the United States or Canada.

Member does not include a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Class Definition: None

SCHEDULE OF INSURANCE

Eligibility Waiting Period: You are eligible on one of the following dates:

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the date you become a Member.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance.

STD Benefit: 60% of the first \$3,333 of your Predisability Earnings, reduced by Deductible Income.

Maximum: \$2,000 before reduction by Deductible Income.

Minimum: \$50

Benefit Waiting Period:

For Noncontributory insurance, Contributory insurance for Members who apply during the Enrollment Period, and for Members who were required to submit Evidence Of Insurability to become insured and it was approved:

For Disability caused by accidental Injury: 7 days

For Disability caused by Physical Disease, Pregnancy or Mental Disorder: 7 days

For Contributory insurance for Members who do not apply during the Enrollment Period:

For Disability caused by accidental Injury: 7 days

For Disability caused by Physical Disease, Pregnancy or Mental Disorder: During the 12-month period beginning on the date your insurance becomes effective: 60 days; and thereafter: 7 days

Enrollment Period for Contributory insurance: The 31-day period beginning on the date you become eligible.

Maximum Benefit Period: 90 days. However, STD Benefits will end on the date long term disability benefits become payable to you under a group plan provided by your Employer, even if that occurs before the end of the Maximum Benefit Period.

If you are Disabled for less than one full week, we will pay one-seventh of the STD Benefit for each day of Disability.

PREMIUM CONTRIBUTIONS

Insurance is: Noncontributory

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan: Short Term Disability Insurance

Name, Address of Plan Sponsor: Super Micro Computer, Inc.
980 Rock Avenue
San Jose CA 95131

Plan Sponsor Tax ID Number: 77-0353939

Plan Number: 501

Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor (408) 953-8868
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Employer
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	December 31

INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay STD Benefits according to the terms of the Group Policy after we receive Proof Of Loss.

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BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

You are a Member if you are:

1. A regular employee of the Employer;
2. Actively At Work at least 30 hours each week (for purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of Active Work on those days); and
3. A citizen or resident of the United States or Canada.

You are not a Member if you are a temporary or seasonal employee, a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

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WHEN YOUR INSURANCE BECOMES EFFECTIVE

A. When Insurance Becomes Effective

Subject to the **Active Work Provisions**, your insurance becomes effective as follows:

1. Insurance Subject To Evidence Of Insurability

Insurance subject to Evidence Of Insurability becomes effective on the date we approve your Evidence Of Insurability.

2. Insurance Not Subject To Evidence Of Insurability

The **Coverage Features** states whether insurance is Contributory or Noncontributory.

a. Noncontributory Insurance

Noncontributory insurance not subject to Evidence Of Insurability becomes effective on the date you become eligible.

b. Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

- i. The date you become eligible if you apply on or before that date; or
- ii. The date you apply if you apply after the date you become eligible.

Note: If you do not apply during the Enrollment Period, then until you have been insured under the Group Policy for 12 consecutive months, you will have a longer Benefit Waiting Period for Disabilities caused by Physical Disease, Pregnancy or Mental Disorder. The Enrollment Period and applicable Benefit Waiting Periods are shown in **Coverage Features**.

B. Takeover Provisions

1. If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.
2. You must submit satisfactory Evidence Of Insurability to become insured if you were eligible for insurance under the Prior Plan for more than 31 days but were not insured.

C. Evidence Of Insurability Requirement

You are required to provide Evidence Of Insurability:

- a. For Members eligible for more than 31 days but not insured under the Prior Plan.
- b. For reinstatements if required.

Providing Evidence Of Insurability means you must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about your health;
3. Undergo a physical examination, if required by us; and
4. Provide any additional information about your insurability that we may reasonably require.

(VAR EOI_WITH 60 DAY PD) ST.EF.OT.3

ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing with reasonable continuity the Substantial And Material Acts of your Own Occupation at your Employer's usual place of business.

B. Changes In Insurance

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

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WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your insurance.
2. The date the Group Policy terminates.
3. The date your employment terminates.
4. The date you cease to be a Member. However, your insurance will be continued during the following periods when you are absent from Active Work, unless it ends under any of the above.
 - a. During the first 90 days of a temporary or indefinite administrative or involuntary leave of absence or sick leave, provided your Employer is paying you at least the same Predisability Earnings paid to you immediately before you ceased to be a Member. A period when you are

absent from Active Work as part of a severance or other employment termination agreement is not a leave of absence, even if you are receiving the same Predisability Earnings.

- b. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
- c. During any other temporary leave of absence approved by your Employer in advance and in writing and scheduled to last 30 days or less. A period of Disability is not a leave of absence.
- d. During the Benefit Waiting Period and while STD Benefits are payable.

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REINSTATEMENT OF INSURANCE

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If you cease to be a Member because of a Disability that is not covered solely because of the exclusion for work related Disabilities, your insurance will end. However, if you become a Member again immediately after workers' compensation temporary benefits end, the Eligibility Waiting Period will be waived.
2. If your insurance ends because you cease to be a Member for any reason other than item 1 above, and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
3. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
4. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
5. In no event will insurance be retroactive.

(NONOCC) ST.RE.OT.4

DEFINITION OF DISABILITY

You are Disabled if you meet either of the following definitions:

1. Definition of Total Disability; or
2. Definition of Partial Disability.

You are required to be Totally Disabled or Partially Disabled from your Own Occupation.

1. Total Disability Definition: You are Totally Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Substantial And Material Acts necessary to pursue your Own Occupation and you are not working in your Own Occupation.
2. Partial Disability Definition: You are Partially Disabled from your Own Occupation if you are not Totally Disabled and you are actually working in your Own Occupation but, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to earn 80% or more of your Predisability Earnings.

Note: You are not Disabled from your Own Occupation merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license. The loss of a professional license, occupational license, or certification does not, in itself, constitute Disability.

You may work in another occupation while you meet the definition of Disability. However, your Work Earnings may be Deductible Income and STD Benefits will end when your Work Earnings meet or exceed 80% of your Predisability Earnings. See **Return To Work Provisions, Deductible Income, and When STD Benefits End.**

Own Occupation may be interpreted to mean the employment, business, trade or profession that involves the Substantial And Material Acts of the occupation you are regularly performing for your Employer when Disability begins. Own Occupation is not necessarily limited to the specific job you perform for your Employer.

Substantial And Material Acts means the important tasks, functions and operations generally required by employers from those engaged in your Own Occupation that cannot be reasonably omitted or modified. In determining what Substantial And Material Acts are necessary to pursue your Own Occupation, we will first look at the specific duties required by your job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other individuals engaged in your Own Occupation. If any specific, material duties required of you by your job differ from the material duties customarily required of other individuals engaged in your Own Occupation, then we will not consider those duties in determining what Substantial And Material Acts are necessary to pursue your Own Occupation.

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RETURN TO WORK PROVISIONS

A. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Definition of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if STD Benefits are payable on that date.

Your Work Earnings will be Deductible Income as determined in 1., 2. and 3:

1. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
2. Determine 100% of your Predisability Earnings.
3. If 1. is greater than 2., the difference will be Deductible Income.

B. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled. Work Earnings includes:

1. Earnings from your Employer.
2. Earnings from any other employer or self employment for which you become employed after the date of your Disability.
3. Any increases, except regularly scheduled increases, in earnings from employment from any other employer or self employment in which you were engaged prior to the date of your Disability.
4. Any sick pay, vacation pay, annual or personal leave pay or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:

1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.
2. Will not be limited to the taxable income you report to the Internal Revenue Service.
3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.
4. May ignore depreciation as a deduction from your gross earnings.
5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.

If we determine that your earnings vary substantially from week to week, we may determine your Work Earnings by averaging your earnings over the most recent four-week period. You will no longer be Disabled when your average Work Earnings over the last four-weeks equal or exceed 80% of your Predisability Earnings.

(NO RTW RESP) ST.RW.CA.2

REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit in an amount agreed to by us, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

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TEMPORARY RECOVERY

You may temporarily recover from your Disability during the Maximum Benefit Period, and then become Disabled again from the same cause or causes, without having to serve a new Benefit Waiting Period. Temporary Recovery means you cease to be Disabled for no longer than the applicable allowable period. See **Definition Of Disability**.

A. Allowable Period

The allowable period of recovery during the Maximum Benefit Period is: a total of 90 days of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Period, the following will apply.

1. The Predisability Earnings used to determine your STD Benefit will not change.
2. The period of Temporary Recovery will not count toward your Maximum Benefit Period.
3. No STD Benefits will be payable for the period of Temporary Recovery.
4. No STD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured during your period of recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

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WHEN STD BENEFITS END

Your STD Benefits end automatically on the earliest of:

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date long term disability benefits become payable to you under a group long term disability policy, even if that occurs before the end of the Maximum Benefit Period.
5. The date benefits become payable to you under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.
6. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.
7. The date your Work Earnings equal or exceed 80% of your Predisability Earnings.

(REV LTD LIM) ST.BE.CA.3

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work. However, if you are a Partner, L.L.C. Owner-Employee, Sole Proprietor or S-Corporation Shareholder, your Predisability Earnings will be based on your Employer's prior tax year or the Policyholder's prior tax year if you are a P.C. Partner. Any subsequent change in your earnings will not affect your Predisability Earnings.

A. Partners, P.C. Partners, L.L.C. Owner-Employees, Sole Proprietors and S-Corporation Shareholders

If you are a Partner, L.L.C. Owner-Employee, Sole Proprietor or S-Corporation Shareholder, Predisability Earnings means your average weekly compensation from your Employer during the Employer's prior tax year. If you are a P.C. Partner, Predisability Earnings means the average weekly compensation received by your professional corporation from the Policyholder during the Policyholder's prior tax year. Your average weekly compensation is determined by adding the following amounts as reported on the applicable Schedule K-1, Schedule C, Form W-2 or S-Corporation federal income tax return, and dividing by 52 (or by the number of weeks you were a Partner, P.C. Partner, L.L.C. Owner-Employee, Sole Proprietor or S-Corporation Shareholder if less than 52):

1. Your ordinary income (loss) from trade or business activity(ies).
2. Your guaranteed payments, if you are a Partner.
3. Your net profit (loss) from business.
4. Your compensation (as an officer), salary, or wages, if you are an S-Corporation Shareholder.

If you were not a Partner, P.C. Partner, L.L.C. Owner-Employee, Sole Proprietor or S-Corporation Shareholder during the entire prior tax year, your Predisability Earnings will be your average weekly compensation for your period as a Partner, P.C. Partner, L.L.C. Owner-Employee, Sole Proprietor or S-Corporation Shareholder.

B. All Other Members

Predisability Earnings means your weekly rate of earnings from your Employer, including:

1. Commissions averaged over the prior 52 weeks or over the period of your employment if less than 52 weeks.
2. Shift differential pay.

Predisability Earnings does not include:

1. Bonuses.
2. Overtime pay.
3. Any other extra compensation.

If you are paid on an annual contract basis, your weekly rate of earnings is one fifty-second (1/52nd) of your annual contract salary.

If you are paid hourly, your weekly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per week, but not more than 40 hours. If you do not have regular work hours, your weekly rate of earnings is based on the average number of hours you worked per week during the preceding 52 calendar weeks (or during your period of employment if less than 52 weeks), but not more than 40 hours.

C. All Members

Predisability Earnings includes:

1. Contributions you make through a salary reduction agreement with your Employer to:
 - a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
 - b. An executive nonqualified deferred compensation arrangement.
2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Predisability Earnings does not include:

1. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan; or
2. Stock options or stock bonuses.

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DEDUCTIBLE INCOME

Subject to **Exceptions To Deductible Income**, Deductible Income means:

1. Your Work Earnings, as described in the **Return To Work Provisions**.
2. Any amount you receive or are entitled to receive because of your disability under a state disability income benefit law or similar law.
3. Any amount you receive because of your disability under any other group insurance coverage, as determined below:
 - a. Determine the amount of your STD Benefit as if there were no Deductible Income, add the amount you receive from any other insurance coverage because of your disability.
 - b. Determine 80% of your Predisability Earnings.
 - c. If a. is greater than b., the difference will be Deductible Income.
4. Any disability or retirement benefits you receive under your Employer's retirement plan.

Your and your Employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of how funds are distributed from the retirement plan.

5. Any earnings or compensation included in Predisability Earnings which you receive or have a right to receive while STD Benefits are payable.
6. Any amount you receive under any unemployment compensation law or similar act or law.
7. Any amount of third party liability payments you receive by judgment, settlement or otherwise (less attorneys' fees).
8. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

(PRIV_NONOCC_WITH RTW_GRP OTHR OFFST_WITH 3RD) ST.DI.CA.1

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.
2. Reimbursement for hospital, medical, or surgical expense.
3. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.
4. Benefits from any individual disability insurance policy.
5. California Workers' Compensation benefits for permanent total or permanent partial disability.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Benefits from the following:
 - a. Profit sharing plan.
 - b. Thrift or savings plan.
 - c. Deferred compensation plan.
 - d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
 - e. Individual Retirement Account (IRA).
 - f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
 - g. Stock ownership plan.
 - h. Keogh (HR-10) plan.
9. The following amounts under your Employer's retirement plan:
 - a. A lump sum distribution of your entire interest in the plan.
 - b. Any amount which is attributable to your contributions to the plan.
 - c. Any amount you could have received upon termination of employment without being disabled or retired.

(PRIV_WITH OTHR OFFST) ST.ED.CA.1

RULES FOR DEDUCTIBLE INCOME

A. Weekly Equivalents

Each week we will determine your STD Benefit using the Deductible Income for the same weekly period, even if you actually receive the Deductible Income in another week.

If you are paid Deductible Income in a lump sum or by a method other than weekly, we will determine your STD Benefit using a prorated amount. We will use the period of time to which the Deductible Income applies. If no period of time is stated, we will use a reasonable one.

If you receive a lump sum refund, withdrawal or distribution of contributions and earnings from your Employer's retirement plan, we will determine your STD Benefit using a lifetime monthly annuity amount, with no survivor income. The annuity will be based on the amount you receive, and on the life expectancy of a person your age on the later of:

- a. The date the lump sum is paid; and
- b. The date STD Benefits become payable.

B. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be entitled. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request.

C. Estimating and Deducting

For any item of Deductible Income that includes amounts you, your Spouse, or your child are entitled to receive, we may reduce your STD Benefit by the amount we estimate you would be entitled to receive if:

1. You have failed to pursue the Deductible Income with reasonable diligence;
2. We have a reasonable, good faith belief that you are entitled to the Deductible Income; and
3. We are able to reasonably estimate the amount that would be payable.

We will not estimate and deduct amounts with respect to a claim for Deductible Income that is pending, so long as you continue to pursue the claim with reasonable diligence.

D. Retirement Benefits

1. Early retirement benefits will be Deductible Income only if you elect early retirement, or if early retirement would not reduce your accrued annuity or pension benefits.
2. Retirement benefits received will not include amounts rolled over or transferred to any eligible retirement plan as defined by the Internal Revenue Code.

E. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

F. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us. You will not receive any STD Benefits until we have been repaid in full. In the meantime, any STD Benefits paid, including the Minimum STD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

ST.RU.CA.1

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay STD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive STD Benefits will not be affected by:

1. Any amendment to the Group Policy that is effective after you become Disabled; or
2. Termination of the Group Policy after you become Disabled.

ST.BA.OT.1

EFFECT OF NEW DISABILITY

If a period of Disability is extended by a new cause while STD Benefits are payable, STD Benefits will continue while you remain Disabled. However, 1 and 2 below will apply.

1. STD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. All provisions of the Group Policy, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

ST.ND.OT.1

DISABILITIES EXCLUDED FROM COVERAGE

A. War

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

C. Work Related

You are not covered for a Disability arising out of or in the course of any employment for wage or profit.

D. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(NONOCC) ST.XD.CA.1

LIMITATIONS

A. Care Of A Physician

During the Benefit Waiting Period, you must be receiving care by a Physician which is appropriate for the condition or conditions causing the Disability. No STD Benefits will be paid for any period of Disability when you are not receiving care by a Physician which is appropriate for the condition or conditions causing the Disability. Appropriate care is the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals. This limitation will not apply after you reach your maximum point of recovery.

B. Occupational Benefits

No STD Benefits will be paid for any period when you are eligible to receive benefits for your Disability under a workers' compensation law or similar law. If your claim for these benefits is accepted, compromised or settled (whether disputed or undisputed), you must repay us for the full amount of any payments we make to you while your claim for occupational benefits is pending.

C. Paid Sick Leave Or Other Salary Continuation

No STD Benefits will be paid for any period when you are receiving paid sick leave pay, annual or personal leave pay, or other salary continuation, including donated amounts, (but not vacation pay) from your Employer.

D. Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

E. Rehabilitation Program

No STD Benefits will be paid for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us and by your Physician, unless your Disability prevents you from participating.

Your failure to participate in the approved program will result in the termination of your benefits.

(NONOCC) ST.LM.CA.1

CLAIMS

A. Notice of Claim

Written notice of claim must be provided to us within 60 days after the date you claim you became Disabled, or as soon thereafter as is reasonably possible.

B. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, you may submit your claim in a letter to us. The letter should include the date Disability began, and the cause and nature of the Disability. Subject to the time period for providing notice of claim, such letter will constitute notice and proof of claim.

C. Time Limits On Filing Proof Of Loss

You must give us Proof Of Loss within 90 days after the end of the Benefit Waiting Period. If your claim was closed, you must give us Proof of Loss within 90 days after the date STD Benefits ended. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

D. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to STD Benefits. Proof Of Loss must be provided at your expense.

For claims of Disability due to conditions other than Mental Disorders, we may require proof of physical impairment that results from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. Examples of clinical and laboratory diagnostic techniques include but are not limited to actual observations upon physical examinations, blood tests, imaging studies (such as x-rays, MRIs and CT scans), electrocardiograms (EKG) and electroencephalograms (EEG).

E. Documentation

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

F. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend STD Benefits if you fail to attend an examination or cooperate with the examiner.

G. Time Of Payment

We will pay STD Benefits within 60 days after you satisfy Proof Of Loss.

STD Benefits will be paid to you at the end of each week you qualify for them. STD Benefits remaining unpaid at your death will be paid to your estate.

H. Notice Of Decision On Claim

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

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

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision.
- d. A description of any additional information needed to support your claim.
- e. Information concerning your right to a review of our decision.
- f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

I. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If we extend the review period, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim on review; and (c) any additional information we need to decide your claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

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

- a. The reasons for our decision.
- b. Reference to the parts of the Group Policy on which our decision is based.
- c. Reference to any internal rule or guideline relied upon in making our decision.
- d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
- e. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

J. Assignment

The rights and benefits under the Group Policy are not assignable.

(PRIV WRDG) ST.CL.CA.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought after the expiration of three years after the date Proof of Loss is required to be given.

ST.TL.CA.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement you make to obtain or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any person claiming benefits a copy of the signed written instrument which contains your misrepresentation.

After insurance has been in effect for two years, during your lifetime, we will not use a misrepresentation by you to reduce or deny your claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of The Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or your Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for fraudulent misrepresentations.

ST.IN.CA.1

CLERICAL ERROR, AGENCY AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and
2. The difference between the amount paid and the amount which would have been paid if the age had been correctly stated.

ST.CE.OT.1

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

ST.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before STD Benefits become payable. No STD Benefits are payable for the Benefit Waiting Period. See **Coverage Features**.

Contributory means insurance is elective and Members pay all or part of the premium for insurance.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group STD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

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

Injury means an injury to the body.

L.L.C. Owner-Employee means an individual who owns an equity interest in an Employer and is actively employed in the conduct of the Employer's business.

Maximum Benefit Period means the longest period for which STD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit Waiting Period. No STD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Noncontributory means (a) insurance is nonelective and the Policyholder or Employer pay the entire premium for insurance; or (b) the Policyholder or Employer require all eligible Members to have insurance and to pay all or part of the premium for insurance.

P.C. Partner means the sole active employee and majority shareholder of a professional corporation in partnership with the Policyholder.

Physical Disease means a physical disease entity or process that produces structural or functional changes in your body as diagnosed by a Physician.

Physician means a licensed medical professional, diagnosing and treating individuals within the scope of the license. The term includes a legally licensed physician, dentist, optometrist, podiatrist, psychologist or chiropractor. Physician does not include you or your spouse, or the brother, sister, parent or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group short term disability insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

STD Benefit means the weekly benefit payable to you under the terms of the Group Policy.

ST.DF.CA.1

ERISA INFORMATION AND NOTICE OF RIGHTS

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA)

A. General Plan Information

The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

2. Right To Obtain Copies Of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Right To Receive A Copy Of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

4. Right To Review Of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

C. Obligations Of Fiduciaries

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

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Additional Procedures For Claims Based on Disability Determinations Filed on or after April 1, 2018

If we deny any part of your claim for a benefit that relies on a disability determination, you will receive a written notice of denial containing a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

If all or part of a claim is denied, you may request a review. Before we issue a decision on review for a benefit that relies on a disability decision, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we will provide such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

F. Plan And ERISA Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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