

By Mail: Office of Regulations and Interpretations,
Employee Benefits Security Administration
Room M-5655
U.S. Dept. of Labor
200 Constitution Avenue NW
Washington D.C. 20210

Re: Re-Examination of Claims Procedure Regulations for Plans Providing
Disability Benefits

RIN No.: 1210-AB39

Regulation: 29 C.F.R. §2560.503

To the DOL and EBSA:

I am writing to discourage the Department from modifying or further delaying the final disability claims regulations (Final Regulation on Claims Procedure for Plans Providing Disability Benefits, 81 Fed. Reg. 92316 (Dec. 19, 2016)) that are now scheduled to go into effect on April 1, 2018.

I am an attorney in Chicago that routinely represents individuals applying for disability insurance and appealing denials of those claims. Our office works with the claims departments on a routine basis. I have first-hand experience of the value of the current claims regulations to disabled individuals and eagerly anticipate the new, fairer regulations to take effect.

While I am grateful for the opportunity to comment on the Department's re-examination of the costs of the final rules governing disability claims, the concerns raised by the industry are not new. Rather, these objections appear to be simply re-argument of the merits of the final rules. Where those rules are based on policy choices that have been made by Congress, by this Department, and by the federal courts interpreting ERISA, another argument about the merits is unnecessary.

Nevertheless, I will address the objections that have been raised that I feel are most in need of a response

Costs Will Not Increase

The industry claims if the final rules go into effect there will be an increase in costs that will increase premiums resulting in less access to disability benefits. These assertions do not ring true.

This costs argument was made in various industry comments to the proposed rules before final adoption. The Department concluded that costs would not outweigh the benefits. The current cry of increasing costs is an argument that has already been considered and

rejected. An agency is not required to "conduct a formal cost-benefit analysis in which each advantage and disadvantage is assigned a monetary value." *Michigan v. Environmental Protection Agency*, 135 S. Ct. 1699, 2711 (2015).

Nonetheless, the Department has asked for data addressing whether costs increased in response to the last set of rules applying to ERISA disability plans that became effective in 2002. In fact, the Department can rely upon information supplied by its own Bureau of Labor Statistics. <https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>. The data shows that access and participation in employer-based disability insurance has *increased*, not decreased, between 1999 and 2014. This increase occurred despite that employment in the service industry has increased, an industry in which employees are the least likely to have access to employer-based disability coverage. This increase also occurred despite the 2000 disability claims regulations and a series of court decisions addressing conflicted decision-making, deemed exhaustion, the need to discuss and explain adverse benefits decisions, and the participants right to respond to new evidence. I would therefore be suspicious of any data supplied by the industry now that suggests employers would abandon disability coverage due to the costs of codifying these principles. This BLS document also demonstrates that the cost of disability insurance is extremely modest. Thus, even if costs did increase, the increase would be so small that it is unlikely to make any difference.

The Department has also asked for data about whether disability premiums increased in response to the adoption of statutory bans on discretionary language clauses in disability policies by some states. Notably, during the time period of the BLS study, many states enacted discretionary clause bans. This includes but is not limited to Arkansas Admin. Code 054.00.101-4 (2013); Cal. Ins. Code §10110.6 (2012); Colo. Rev. Stat. §16-3-1116 (2008); 50 Ill. Admin. Codes 2001.3 (2005); Md. Code ann. Ins. §12-211; Mich. Admin. Codes. R. 500.2201-2202 (2007); R.I. Gen. Law §§ 27-18-79; Tex. Admin. Code §3.1202-1203; Tex. Ins. Code §1701.062, §1701.002 (2011); WAC §284-96-012 (2009). Notwithstanding these statutory developments, access and participation in disability plans increased according to the BLS data.

Also, during the period covered by the BLS document, two major insurers with significant market share, UNUM and CIGNA, were examined by the states for poor claims handling and became subject to fines and Regulatory Settlement Agreements that raised the bar for their claims administration. http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2004/unum_multistate/unum_multistate.html; http://www.maine.gov/pfr/insurance/publications_reports/exam_rpts/2009/pdf/cigna_mcreport_2009.pdf. https://www.insurance.ca.gov/0400-news/0100-press_releases/2013/release044-13.cfm. Nonetheless, during this period access and participation increased.

Given this history, I dispute any claim that costs will increase in response to the modest changes in the final rules. Accordingly, I urge the Department not to change the final rules in response to the industry's strained logic that the costliness of the final rules will impact access to disability benefits in the workplace.

The Benefits Outweigh the Costs

The Department is not required to avoid all regulations that affect the market in some way. *Mkt. Synergy Grp. v. United States Dep't of Labor*, 2016 U.S. Dist. LEXIS 163663, 2016 WL 6948061 (D. Kan. 11/28/2016). As well, it is not clear that, whatever the costs of the final rules, they would outweigh the benefits. The Department has already articulated its purposes – to make sure claims are fairly adjudicated and to prevent unnecessary financial and emotional hardship. The Department should ignore the industry's invitation to abandon these purposes. Moreover, these benefits cannot be outweighed by costs where the ERISA process is already so slanted in favor of the plan administrators.

ERISA disability claimants who are denied their benefits face a process that is far below the standard for regular civil disputes. These procedural hurdles include: (1) there are no jury trials; (2) there is a closed record from the claims process that can rarely be supplemented in litigation; (3) courts often apply an unfavorable standard of review, and (4) there are no remedies to discourage unfair and self-serving behavior on the part of plans. This will never be a level playing field much less one that favors plan participants. *United States v. Aegerion Pharmaceuticals, Inc.*, 2017 WL 5586728, at *7 (D.Mass. 11/20, 2017)(“The insurance industry found it could largely immunize itself from suit due to the Employee Retirement Income Security Act (“ERISA”).) Even with the final rules in place, plan participants will not have achieved the “higher-than-marketplace standards” that the Supreme Court insists are required in processing ERISA claims. *MetLife v. Glenn*, 554 U.S. 105, 115 (2008). Any consideration the Department makes about the benefits of the final rules relative to costs should take this “higher-than-marketplace” expectation into account and acknowledge that ERISA exists to protect plan participants.

The Department has already acknowledged that the disability claims industry has been needlessly adversarial toward ERISA disability plan participants and has received many comments to that effect. The industry's argument that the final rules are bad for participants – despite all evidence to the contrary - cannot be taken seriously. The industry is not a credible advocate for participants.

Furthermore, from the perspective of plan participants, an inexpensive but illusory disability plan is worse than no plan at all. It is important to note that when a disability claimant is unfairly denied benefits that he/she thought was promised through an employer's plan, it is too late to go out and purchase private individual insurance to

cover the risk of becoming destitute. Disabled claimants are often shocked when they are told about ERISA's procedural hurdles.

Many claimants are also led by the insurer to believe the insurer will proactively assist with the application of their claim. Yet when we are hired to assist with an appeal, we often find that requests for medical records are not sent, doctors are not called and asked about their return-to-work opinion, and file reviews are completed in a conclusory, slipshod manner. We understand that mistakes are made and the onus falls on the insured to provide proof of loss – we are just looking for a modicum of protection against outwardly hostile, bad faith behavior (for example, by allowing the claimant the last word before a final decision is rendered). The new regulations are designed to address this.

So, to the extent that increased protections bring disability claims administration in line with the reasonable expectations of the employee-participants, the costs are outweighed by the benefits. If there are costs associated with the final regulations, these costs could and should be tolerated in the name of supplying a modicum of protection for plan participants.

Requiring the Plan to Discuss the Basis for Disagreement with Social Security Decisions or Other Contrary Opinions is Not Costly.

This rule merely requires disability plans to observe a fundamental due process principle that is imbedded in ERISA—namely the principle that a claimant is entitled to a well-articulated explanation for the adverse benefits decision so that the participant may fairly dispute it. The 2000 regulations require no less.

As the Department has already noted, it is doubtful that there are costs associated with the requirement of discussing the reasons for disagreeing with a favorable Social Security decision. ERISA disability benefits have always been deeply intertwined with the Social Security system and mostly are simply supplemental to Social Security benefits. Most disability plans require claimants to apply for the SSA benefit, and the plans usually provide representation for claimants before the SSA. This is done so that the plan may take advantage of the plan term that the SSDI benefit will offset the LTD benefit. Indeed, in many cases the ERISA disability benefit is *de minimis* or non-existent once this offset is taken. In order to decide which claimants qualify for this representation, plan claims handlers need to know the standard that the SSA uses. Comment #114, p.8 (ACLI). Disability claims administrators' operational manuals devote many pages to deciding whether the claimant is disabled enough to be referred to counsel for representation before the Social Security Administration, and how to offset or recover the benefits once they are successful, and how to express all of this to the claimant.

To the extent that the industry argues that increasing the cost of disability insurance will burden the government, and more specifically the SSA, the Bureau of Labor Statistics publication speaks to this:

It is important to note that expanding access to employer-provided disability insurance would not necessarily relieve the burden on SSDI. The ability to access disability insurance does not affect a worker's eligibility for SSDI. People can receive SSDI benefits and long-term disability payments, but the private disability insurance payment is usually reduced by the amount of the SSDI payment.

<https://www.bls.gov/opub/btn/volume-4/disability-insurance-plans.htm>.

Additionally, the disability plans and insurers are required in many jurisdictions to discuss why they are denying a disability claim when the Social Security Administration awarded benefits under an obviously more strenuous standard. *Montour v. Hartford Life & Acc. Ins. Co.*, 588 F.3d 623, 635-637 (9th Cir. 2009); *Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666, 679 (9th Cir. 2011); *Bennett v. Kemper Nat. Services Inc.*, 514 F.3d 547, 553-554 (6th Cir. 2008); *Brown v. Hartford Life Ins. Co.*, 301 F. App'x 777, 776 (10th Cir. 2008). As a matter of Supreme Court precedent, it is arbitrary and capricious for the claims administrator to advocate for Social Security benefits, reap the benefit of the Social Security award by means of an offset, and then ignore the SSA's determination. *Metropolitan Life v. Glenn*, 554 U.S. 105 (2008). As the industry comments often acknowledged, requiring an explanation of the reasons for disagreeing with the Social Security decision and other contrary evidence tracks the existing standard. Logically, it should not increase costs to simply codify this standard.

A rule clarifying that an explanation of the basis for disagreeing with a Social Security decision is a requirement will increase uniformity and predictability in the process, which is generally associated with costs savings and not cost increases.

The Deemed Exhausted Rule is Not Costly

The industry's concern about this rule seems to be that plaintiffs and their attorneys will race into court, increasing the volume of ERISA litigation and hence the overall costs of administering disability claims. This is incorrect. Plaintiff's attorneys are ever mindful of building a record on which the court will make its decision and therefore would rather engage in the appeal process and exhaust internal remedies. This serves the dual purpose of possibly resolving the dispute and creating a record for the court to review in case the dispute cannot be resolved internally. Under the final rule, the plaintiff will mostly obtain a remand with instructions for the plan to do its job. Because plaintiff's attorneys usually work on a contingent fee basis, it does not make sense to undertake litigation that is not absolutely necessary and that will not result in resolving the case on the merits.

Further, a court will only award attorney fees for litigation where the plaintiff has achieved some degree of success on the merits. *Hardt v. Reliance Standard Life Ins. Co.*, 560 U.S. 242, 255 (2010). In other words, the industry comments are seriously out of step with litigation in the real world and how the incentives are aligned to discourage litigation. While this rule may appear to create additional trips to court, it will not do so except in the most extreme cases. I take it that addressing these extreme cases is the purpose of the final deemed denied rule.

Additionally, as with most of the other final rules, this rule is simply a codification of existing judge-made law. Claimants are already able to get into court when the claims process has failed them in a meaningful way. See e.g. *Brown v. J.B. Hunt Transp. Servs.*, 586 F.3d 1079, 1085-86 (8th Cir. 2009) (failure to respond to request for documents excused claims from exhaustion requirement because there was no full and fair review). It is not likely that additional costs will result from this regulation. *Hall v. National Gypsum Co.*, 105 F.3d 225, 231-32 (5th Cir. 1997); *LaAsmar v. Phelps Dodge Corp. Life*, 605 F.3d 789 (10th Cir. 2010); *Nichols v. Prudential Ins. Co. of Am.*, 406 F.3d 98 (2d Cir. 2005); *Jebian v. Hewlett-Packard Co. Employee Benefits Org. Income Prot. Plan*, 349 F.3d 1098 (9th Cir. 2003); *Dunnigan v. Metropolitan Life Ins. Co.*, 277 F.3d 223, 231 n.5 (2d Cir. 2002).

Providing the Right to Review and Respond to New Evidence or Rationale From the Plan During the Appeal Review is Not Costly.

This rule is fundamental to full and fair review. The Department has already acknowledged the importance of this rule and that it is already the standard in some jurisdictions. The industry complains that providing the claimant with new evidence or rationales before making a final decision is costly. The industry's claim to cost impact is suspect for several reasons.

First, several disability plans or insurers already provide for the right to review and respond. They do so on a voluntary basis, as their comments to the proposed rules showed. Second, courts require plans or insurers to do this in many cases. Last, whether they provide this information to the claimant during the ERISA appeal process, they will have to provide it eventually in one form or another. New reasons or evidence will need to be included in the claim file and likely again in 26(a)(1) disclosures. Thus, the industry's portrayal of the chaos that might ensue if they were required to supply these documents is not credible. If the issue is the cost of mailing, such a concern should not be permitted to interfere with such basic a due process right.

It is important to note what this rule does. It permits a claimant to respond to a disability claims administrator's assertions in a way that will make the response a part of the record if the claimant has to go to court to vindicate his/her rights. This is because most ERISA

cases are decided on a closed record. Without this rule, the claims administrator's new evidence or rationale will be included in the record that the court reviews, but the claimant's rebuttal will not. Perhaps what the industry is really chafing about is the loss of its ability to strategically withhold information that would help the claimant achieve reversal or win his/her case in court.

There is no question in my mind, after years of experience representing ERISA claimants, that the ability to sandbag the claimant with a new medical opinion that he/she cannot refute, or a new plan provision to rely upon that he/she cannot counter, is a prized device in the disability claims industry. The final rule needs to be kept in place to prevent the insurers from stamping out otherwise meritorious disability claims.

We were recently forced to file suit in a case where the doctor reviewing on appeal clearly indicated restrictions that rendered the claimant disabled. Nonetheless, claims department upheld its decision without allowing our firm to review and address the report, requiring us to file suit. The suit quickly settled – at an extra cost to the judiciary and the participant. See, *Stano v. Life Ins. Co. of N.A.*, Case No. 1:16-cv-10158 (N.D. Ill., filed October 28, 2016) (enclosed). That outcome could have been easily avoided with the protections afforded by the final rules.

If the industry's concern is that the claims handlers need to do more in the same amount of time, this could be addressed by modifying the rule instead of eliminating the rule altogether. Commenters from both sides have suggested as much.

I also dispute the industry's comments to the effect that a second appeal, which is offered with some plans, serves the same purpose as the right to respond to new evidence or rationales before a final decision. This is clearly not true, as a second appeal permits the claims administrators the same sandbagging opportunity as the first appeal. Second appeals are not necessarily a boon to plan participants. Additionally, second appeals are not universal and are not required. The second appeals that the industry touts are a matter of plan design and can be changed at any time by plan sponsors. It may be that second appeals will become obsolete where the claimant has a true right to respond.

Other Provisions

The Impartiality Rule

Few industry commenters complained about the proposed rule requiring that consulting experts be impartial. Comment #76 (UNUM), Comment #92 (NFL), Comment #129 (AHIP). This muted objections are understandable, since it is hard to argue that disability claims administrators should be free to hire biased experts. The majority of those who

object to this rule admitted that the proposed rule reflects the existing law. Comment #76, (UNUM), Comment #92 (NFL). The industry complaints seem to be based on the fear of increased litigation, particularly in the form of discovery. First, federal judges are well versed at limiting discovery in ERISA cases in proportion to the needs of the case. See e.g. *Paquin v. Prudential Ins. Co. of Am.* 2017 WL 3189550 (D. Colo. 7/10/2017); *Heartsill v. Ascension Alliance*, 2017 WL 2955008 (E.D. Mo. 7/11/2017; *Ashmore v. NFL Player Disability and Neurocognitive Benefit Plan*, 2017 WL 4342197 (S.D. Fla. 9/27/2017); *Baty v. Metropolitan Life Ins. Co.*, 2017 WL 4516825 (D. Kan. 10/10/2017); *Harding v. Hartford Life and Accident Ins. Co.*, 2017 WL 1316264 (N.D. Ill. 4/10/2017); *Hancock v. Aetna Life Ins. Co.*, 321 F.R.D. 383 (W.D. Wash. 2017); *Kroll v. Kaiser Foundation Health Plan Long Term Disability Plan*, 2009 WL 3415678 (N.D. Cal. 10/22/2009). Next, if the impartiality rule is already the law, it is not clear how more discovery would result from codifying it. Additionally, the credibility of experts who are opining on whether a claimant qualifies for benefits should be subject to some sort of scrutiny. If a claimant needs to conduct discovery into whether a physician hired by the administrator is well-known to support denials, the cost of conducting this discovery cannot possibly outweigh the benefits. ERISA claimants are entitled to a process that does not have a predetermined outcome based on which reviewing physician is hired by the plan. This final rule addresses a serious problem in the ERISA disability claims process and should remain.

The Rule Requiring Disclosure of any Internal Limitations Period

Few industry commenters focused on the final rule requiring claims administrators to provide the claimant with the date when any internal time limit for filing suit will expire. I am assuming, therefore, that these objectors are not claiming that this rule has a cost impact. The claims administrators are in a position to satisfy this rule, since the expiration date of an internal limitations period is essentially a plan term that should be accessible to the plan administrator and not be hidden from unsuspecting plan participants. As with most of the final rules, information respecting the period of limitations is required to be disclosed in several jurisdictions, so it is unlikely to incur additional costs to create uniformity. *Santana-Diaz v. Metro. Life Ins. Co.*, 816 F.3d 172, 179 (1st Cir. 2016); *Moyer v. Metro. Life Ins. Co.*, 762 F. 3d 503, 505 (6th Cir. 2014); *Mirza v. Ins. Adm'r of America, Inc.*, 800 F. 3d 129, 134 (3d Cir. 2015).

The Rule Requiring Disclosure of Internal Guidelines

Few commenters objected to the proposed rule requiring claims administrator to disclose internal guidelines or certify that none exist. Comment #50 (DRI), Comments #76 (UNUM). These commenters complained that internal guidelines tend to be procedural rather than substantive, implying that the guidelines are irrelevant. As this lengthy rulemaking process has shown, procedure affects substantive outcomes. So even if internal guidelines are procedural, that is no reason to withhold those guidelines from claimants. The disclosure of claims manuals and internal guidelines, which often contain additional plan terms that are hidden from the ERISA participants, will ultimately cut

down on litigation, since discovery of these documents is often disputed. *See Glista v. Unum Life Ins. Co. Of Am.*, 378 F.3d 113, 123-125 (1st Cir. 2004); *Mullins v. AT&T Corp.*, 290 Fed. Appx. 642, 646 (4th Cir. 2008).

Very Truly Yours,

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Encl.

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

H	STANO,)	
)	
	Plaintiff,)	
)	
	v.)	No.
)	
	LIFE INSURANCE COMPANY)	
	OF NORTH AMERICA,)	
)	
	Defendant.)	

COMPLAINT

Now comes the Plaintiff, H STANO, by her attorneys, MARK D. DEBOFSKY, WILLIAM T. REYNOLDS, and DEBOFSKY, SHERMAN & CASCIARI, P.C., and complaining against the defendant, LIFE INSURANCE COMPANY OF NORTH AMERICA, she states:

Count I

Nature of Action

1. Jurisdiction of the court is based upon the Employee Retirement Income Security Act of 1974 (“ERISA”); and in particular, 29 U.S.C. §§ 1132(e)(1) and 1132(f). Those provisions give the district court jurisdiction to hear civil actions brought to recover benefits due under the terms of an employee welfare benefit plan, which, in this case, consists of a group-long term disability (“LTD”) insurance policy (“the Policy”), underwritten and administered by Life Insurance Company of North America (“LINA”), for the benefit of employees of Alexian Brothers Health System, which includes Plaintiff. Additionally, this action may be brought before this court pursuant to 28 U.S.C. 1331, which gives the district court jurisdiction over actions that arise under the laws of the United States.

2. The ERISA statute provides, at 29 U.S.C. § 1133, a mechanism for administrative

or internal appeal of benefit denials. Those avenues of appeal have been exhausted.

3. Venue is proper in the Northern District of Illinois. 29 U.S.C. § 1132(e)(2); 28 U.S.C. § 1391.

Nature of the Action

4. This is a claim seeking recovery of disability benefits claimed to be due under an employee welfare benefit plan, which provided insured long-term disability benefits under policy number LK-961924 (“the Policy”). This action is brought pursuant to ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)). Plaintiff also seeks attorneys’ fees pursuant to 29 U.S.C. § 1132(g) and ERISA § 502(g).

The Parties

5. The plaintiff, H STANO (“Stano” or “Plaintiff”), age 64 (born in 1952), is a resident of Lake in the Hills, McHenry County, Illinois and was employed in Elk Grove Village, Cook County, Illinois.

6. The defendant, LINA, was at all times relevant hereto doing business throughout the United States and within the Northern District of Illinois, and delivered coverage to Plaintiff in the State of Illinois.

Statement of Facts

7. From September 1986 until June 13, 2012, Stano was successfully employed as a Nurse with Alexian Brothers Medical Center in Elk Grove Village, Illinois.

8. As a benefit of her employment with Alexian Brothers, Plaintiff received long-term disability coverage under a group disability insurance policy administered by Defendant. The Policy defines the term “Disabled” as follows:

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. Unable to perform the material duties of his or her Regular Occupation; and
2. Unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. Unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. Unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

(A true and correct copy of the entire policy of the disability insurance is attached hereto and incorporated herein as Exhibit "A").

9. On June 13, 2012, Plaintiff was forced to leave work due to the combination of several worsening physical and psychiatric impairments including spinal stenosis, rheumatoid arthritis, spondyloarthropathy, bilateral plantar fasciitis, right-sided facet joint disease, bursitis and tendinitis of the bilateral Achilles tendons, depression, and anxiety. Those conditions have and continue to cause chronic, diffuse pain in Stano's back, legs, feet, and arms, musculoskeletal pain and stiffness, severe fatigue, neurological weakness of the legs, unstable mood, and other related symptoms.

10. After she ceased working, Stano submitted a timely claim for disability insurance benefits to LINA. LINA found Stano eligible for short term disability ("STD") benefits on July 9, 2012 and paid STD benefits through that policy's exhaustion period on November 12, 2012.

11. After STD benefits were exhausted, LINA subsequently approved Plaintiff's claim for long term disability ("LTD") benefits under the terms of the Policy in the amount of \$3,837 per month. LINA continued to pay LTD benefits without interruption through December 11, 2014.

12. While LINA was paying LTD benefits, it encouraged Stano to apply for Social Security Disability Insurance ("SSDI") benefits. LINA offered Stano assistance in applying for SSDI benefits by referring her to a vendor for representation and by agreeing to pay that representative's fee in the event of an award of SSDI benefits.

13. On March 21, 2013, Stano's application for SSDI benefits was approved by the Social Security Administration following the Agency's review of independent medical examination reports and records and opinion from Stano's treating physicians. The award signified that she was incapable of "any gainful activity" – the definition of "disabled" under Social Security Act, 42 U.S.C. § 423(d)(1)(A) – due to the combination of her severe impairments.

14. As a result of Stano's SSDI award, the Policy permitted LINA to reduce the amount of Stano's monthly LTD benefit at a dollar-for-dollar rate in accordance with her SSDI monthly benefit amount, from \$3,837 per month to \$1,976 per month. LINA was also able to recover approximately \$11,000 in overpaid LTD benefits from Stano based upon the retroactive award.

15. Stano's physical condition continued to deteriorate after her disability began. On September 4, 2013, rheumatologist Andrew Jasek, M.D. found that she had diminished range of motion in the lumbar spine, abnormal Schober's test, discomfort on internal rotation of both hips, slightly enlarged left wrist, and swollen feet. On December 18, 2013, Dr. Jasek's treatment notes explicitly stated that Stano's condition was continuing to worsen and was unresponsive to treatment. On April 9, 2014, laboratory analysis showed Ms. Stano suffering from low white blood

cell counts, low mean cell hemoglobin concentration, low anion gap differential, low creatinine levels, low thyroid stimulating hormone, high cholesterol, and high rheumatoid factor.

16. On April 12, 2014, Ms. Stano reported to LINA in a Disability Questionnaire that she completed at LINA's request that she suffered from constant lower back pain, hip pain that increases with increased activities, hand numbness, difficulty bending, general weakness, tiredness, hand weakness, difficulty holding objects, difficulty walking, difficulty sitting, dizziness, difficulty sleeping, and difficulty coping with stress. She also reported that she walks short distances and requires the use of handrails. Records from Dr. Janek dated April 16, 2014 indicated diagnoses of rheumatoid arthritis, spondyloarthropathy, plantar fasciitis bilateral, and Achilles bursitis/tendinitis.

17. On July 28, 2014, physical therapist Rachel Viel, MSPT, examined Ms. Stano and reported observing the following: a slow gait pattern, single sidestepped stair climbing and descending, standing and sitting with decreased lumbar lordosis, grossly decreased active trunk range of motion by 50% in all directions, decreased bilateral lower extremity strength with cogwheeling present at all joints, grossly decreased active cervical range of motion by 50%, and an inability to lift any weight because it was too painful.

18. On October 28, 2014, LINA sent notice to Ms. Stano that her LTD benefits would terminate beyond the Policy's change to the any occupation definition of disability on December 11, 2014. LINA based its decision upon a Transferrable Skills Analysis that asserted Ms. Stano could work as a Cardiac Monitor Technician, Contact Representative, or Nurse Consultant with the following prescribed functional limitations: rare to occasional standing and walking, occasional fine and course gripping, grasping, and manipulating, and no reaching overhead,

climbing, repetitive wrist movements, crouching, crawling, or kneeling. In reaching its decision, LINA only considered two physical therapy notes dated April 16, 2014 and July 8, 2014.

19. On November 10, 2014, laboratory testing again showed that Ms. Stano's rheumatoid factor was elevated. Additional laboratory testing completed November 28, 2014 further showed high levels of chloride, low anion gap differential, low Albumin/Globulin ratio, high aspartate aminotransferase test (SGOT) level, high cholesterol, low thyroid-stimulating hormone level, high level of hemoglobin A1C, and a low white blood cell count. A pelvic MRI completed December 15, 2014 further revealed: (1) hyperplastic marrow of the visualized lumbosacral spine, sacrum, and coccyx probably indicating; (2) significant degenerative changes of the L4-L5 and L5-S1 discs with disc space narrowing, desiccation of the disc, and end plate signal abnormalities; (3) mild right L5 foraminal compromise; and (4) a 9 mm Tarlov/perineural cyst in the left of the midline at S1/S2.

20. On June 9, 2015, Plaintiff, through counsel, submitted an appeal of LINA's decision to terminate benefits. Included with the appeal were a medical assessment questionnaire completed by Dr. Monika Rolek, updated medical records, witness statement letters, commendation letters from former patients, and vocational information detailing the demands of the occupations LINA identified Ms. Stano as capable of performing.

21. Despite the submission of this irrefutable information, LINA upheld its decision to terminate Plaintiff's LTD benefits in a letter dated November 24, 2015. At no point during the time it was paying benefits or during the initial claim appeal process did LINA exercise its authority to have Ms. Stano examined by a neutral third-party physician.

22. On May 9, 2016, Plaintiff, through counsel, submitted a second appeal of LINA's decision to terminate her benefits. Included with the second appeal were an updated, expanded

residual functional capacity questionnaire form from Dr. Rolek, updated medical records, a full copy of her SSA claim file, and copies of the 2013 Regulatory Settlement Agreement that LINA entered in to with the state insurance commissioners in which it pledged to adhere to certain claim handling processes including full consideration of awards of SSDI benefits and providing full, thorough, and fair evaluation of all claims.

23. Upon submission of her second appeal of LTD benefits, LINA, for the first time, compelled Stano to undergo a medical examination. Although Plaintiff's counsel twice requested to review a copy of IME examiner Dr. Ibrahim Sadek's report prior to LINA's final determination, LINA refused to provide the report or give Plaintiff an opportunity to respond. It was only after the final claim appeal denial that Defendant produced the examination report.

24. On August 4, 2016, LINA upheld its termination of Stano's LTD benefits. Purportedly relying upon Dr. Sadek's findings, LINA claimed Stano retained the following functional capacity:

Given the above findings, your client would be capable of the following activities throughout an 8-hour workday:

- Constant: seeing, hearing
- Frequent: sitting, reaching at desk level, bilateral fine manipulation and simple grasping
- Occasional: stand, walk, reaching below waist, lifting/carrying/pushing/pulling up to 10 pounds, using lower extremities for foot controls
- Not able: reaching overhead, bilateral firm grasping, climbing stairs/ladders, balancing, stooping, kneeling, crouching, crawling

This determination is in direct contrast to the actual findings of Dr. Sadek, who stated in his report:

Ms. Stano in my opinion is physically functionally impaired from December 11, 2014 and ongoing. Although her condition seems to have been somewhat stabilized during that period, she continues to suffer from severe lower lumbar spine degenerative disease mostly at L4-5 and L5-S1 with severe spinal stenosis and foraminal narrowing as evidenced by several MRI reports. Also multiple joint pain, stiffness and limitation to range of motion mostly involving both shoulders, and knees and to a lesser extend both hips, with diagnosis of rheumatoid arthritis with

positive rheumatoid factor causing her severe stiffness in gait and movement. She also has significant weakness to both upper and lower extremities as evidenced by her examination today.

Work restrictions would be medically necessary as claimant cannot sit and/or stand more than 10-15 minutes, must change positions frequently, with limitations to her lifting, carrying, pushing, pulling and other maneuvers as detailed in the physical abilities assessment form. This opinion is based on my professional experience, my review of medical records, and today's examination.

(A true and correct copy of the entire IME report is attached hereto and incorporated herein as Exhibit "B").

25. LINA termination of Stano's LTD benefits was and remains against the weight of the medical evidence and is in direct contrast to the opinion of its own hired examining doctor. LINA's decision to terminate Plaintiff's LTD benefits was therefore the product of biased claims handling and was the result of a conflict of interest rooted in unfounded and unsupported file reviews performed by non-consulting physicians and vocational analysts routinely contracted by LINA and by an erroneous and biased interpretation and misstatement of Dr. Sadek's findings. Stano thus remains entitled to LTD benefits due since December 11, 2014 plus any interest that has accrued thereon; and she is also entitled to a declaration of rights that her benefits remain payable thereafter so long as she continues to meet the Policy's terms and conditions.

26. All avenues of administrative appeal to LINA have now been exhausted, and this matter is therefore ripe for adjudication.

Relief Sought

WHEREFORE, Plaintiff prays for the following relief:

A. That the court enter judgment in Plaintiff's favor and against the Defendant and that the court order the Defendant to pay all accrued long-term disability benefits to Plaintiff in an amount equal to the contractual amount of benefits to which she is entitled from December 11,

2014s to the present;

B. That the Court order the Defendant to pay Plaintiff compounding prejudgment interest on all contractual benefits that have accrued prior to the date of judgment in accordance with 29 U.S.C. § 1132(a)(1)(B) or 29 U.S.C. § 1132(a)(3);

C. That the Court order Defendant to continue paying Plaintiff LTD benefits in an amount equal to the contractual amount of benefits to which she is entitled through the Policy's Maximum Benefit Period, so long as she continues to meet the policy conditions for continuance of benefits;

D. That the Court award Plaintiff her attorney's fees pursuant to 29 U.S.C. § 1132(g);
and

E. That Plaintiff be awarded any and all other contractual and/or equitable relief to which she may be entitled, as well as the costs of suit.

October 28, 2016

Respectfully Submitted,

Mark D. DeBofsky
One of the Plaintiff's Attorneys

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William T. Reynolds
DeBofsky, Sherman & Casciari, P.C.
200 West Madison St, Suite 2670
Chicago, IL 60606
(312) 235-4880 (phone)
(312) 929-0309 (fax)

EXHIBIT A

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Alexian Brothers Health System
(herein called the Policyholder)

Policy No.: LK-961924

The Company and the Policyholder hereby agree that the Policy is amended as follows:

1. Effective January 1, 2012, the following shall be added to the Schedule of Affiliates under the Policy:

Bonaventure House

2. Effective January 1, 2012, the Eligibility Waiting Period under the *Schedule of Benefits for Class 1* is replaced by the following:

Eligibility Waiting Period

If you were hired on or before the Policy Effective Date:

Alexian Brothers Health System:

The first of the month following 30 days continuous Full-time employment.

Alexian Brothers Medical Center:

After 365 days of continuous Full-time employment

Saint Alexius Medical Center:

After 365 days of continuous Full-time employment

Alexian Brothers Behavioral Health Hospital:

After 365 days of continuous Full-time employment

Thelen Corporation:

After 365 days of continuous Full-time employment

Bonaventure House:

After 365 days of continuous Full-time employment, for Associates acquired from Ascension Health, the original date of hire under Ascension applies.

If you were hired after the Policy Effective Date:

After 365 days of continuous Full-time employment

3. Effective January 1, 2012, Class 1 under the Classes of Eligible Employees provision of the *Schedule of Benefits* section of the Policy are replaced by the following:

Class 1 All Associates of Alexian Brothers Health System, Alexian Brothers Medical Center, Saint Alexius Medical Center, Alexian Brothers Behavioral Health Hospital, Alexian Brothers Medical Group, Thelen Corporation and Bonaventure House who are active, Full-time Associates scheduled to work at least 72 hours per bi-weekly pay period and Associates that were classified as Full-time as of January 1, 2004.

Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



Matthew G. Manders, President

Date: March 9, 2012

Amendment No. 05
TL-004780

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Alexian Brothers Health System
(herein called the Policyholder)

Policy No.: LK-961924

The Company and the Policyholder hereby agree that the Policy is amended as follows:

1. Effective January 1, 2012, the term Employee has been replaced with the term Associates through out the Policy for Classes 1 and 2:
2. Effective January 1, 2012, the definition of Associate under the Definitions section of the Policy is has been added to the Policy:

Associate

For eligibility purposes, you are an Associate if you work for the Employer and are in one of the "Classes of Eligible Associates." Otherwise, you are an Associate if you are an Associate of the Employer who is insured under the Policy.

Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



Matthew G. Manders, President

Date: January 18, 2012

Amendment No. 04

TL-004780

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Alexian Brothers Health System
(herein called the Policyholder)

Policy No.: LK-961924

The Company and the Policyholder hereby agree that the Policy is amended as follows:

Effective January 1, 2012, the following rates will be in force for Classes 1 and 2 for coverage under the Policy:

\$.27 per \$100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed \$16,667.

No change in rates will be made until 36 months after the effective date of this Amendment. However, the Company reserves the right to change the rates at any time during a period for which the rates are guaranteed if the conditions described in the Changes in Premium Rates provision under the Administrative Provisions section of the Policy apply.

Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



Matthew G. Manders, President

Date: September 29, 2011

Amendment No. 03

TL-004780

LIFE INSURANCE COMPANY OF NORTH AMERICA
(herein called the Company)

Amendment to be attached to and made a part of the Group Policy
A Contract between the Company and

Alexian Brothers Health System
(herein called the Policyholder)

Policy No.: LK 961924

The Company and the Policyholder hereby agree that the Policy is amended as follows:

1. Effective June 14, 2009, Class 1 under the Classes of Eligible Employees provision of the *Schedule of Benefits* section of the Policy are replaced by the following:

Class 1 All Employees of Alexian Brothers Health System, Alexian Brothers Medical Center, Saint Alexius Medical Center, Alexian Brothers Behavioral Health Hospital, Alexian Brothers Medical Group and Thelen Corporation who are active, Full-time Employees scheduled to work at least 72 hours per bi-weekly pay period and Employees that were classified as Full-time as of January 1, 2004.

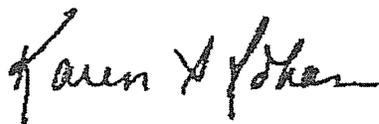
2. Effective June 14, 2009, the following shall be added to the Schedule of Affiliates under the Policy:

Alexian Brothers Medical Group

3. Effective June 14, 2009, Class 2 under the Classes of Eligible Employees provision of the *Schedule of Benefits* section of the Policy are terminated under the policy:

Except for the above, this Amendment does not change the Policy in any way.

FOR THE COMPANY



By:

Karen S. Rohan, President

Date: June 23, 2009

Amendment No. 01

TL-004780

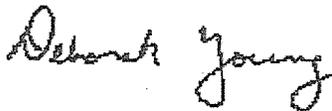
LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(800) 732-1603 TDD (800) 552-5744
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER: Alexian Brothers Health System
POLICY NUMBER: LK-961924
POLICY EFFECTIVE DATE: January 1, 2009
POLICY ANNIVERSARY DATE: January 1

This Policy describes the terms and conditions of coverage. It is issued in Illinois and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Policyholder have agreed to all the terms of this Policy.



Deborah Young, Corporate Secretary



Karen S. Rohan, President

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SCHEDULE OF BENEFITS

Premium Due Date: The last day of each month

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If an Employee is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in his or her insurance due to the class change will be effective on the date of the change in class.

- Class 1 All Employees of Alexian Brothers Health System, Alexian Brothers Medical Center, Saint Alexius Medical Center, Alexian Brothers Behavioral Health Hospital and Thelen Corporation who are active, Full-time Employees scheduled to work at least 72 hours per bi-weekly pay period and Employees that were classified as Full-time as of January 1, 2004.

- Class 2 All Employees of Bonaventure Medical Group who are active, Full-time Employees scheduled to work at least 72 hours per by-weekly pay period and all Full-time physicians scheduled to work at least 32 patient contact hours per week.

SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:

Alexian Brothers Health System:

The first of the month on or after 30 days continuous Full-time employment.

Alexian Brothers Medical Center:

After 365 days of continuous Full-time employment

Saint Alexius Medical Center:

After 365 days of continuous Full-time employment

Alexian Brothers Behavioral Health Hospital:

After 365 days of continuous Full-time employment

Thelen Corporation:

After 365 days of continuous Full-time employment

For Employees hired after the Policy Effective Date:

After 365 days of continuous Full-time employment

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay for more than 40 hours per week or other extra compensation. Monthly Covered Earnings will be figured by multiplying Covered Earnings by 4.333.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	180 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	\$10,000 per month
Minimum Disability Benefit	\$100 per month

Disability Benefit Calculation

The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive

During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Additional Benefits

Catastrophic Disability Benefit

Amount of Benefit: 25% of an Employee's monthly Covered Earnings to a maximum monthly benefit of \$5,000.

Specified Loss Benefits

Time Period for Accident 90 days

Table for Accidental Loss

<u>Loss</u>	<u>Benefit Period</u>
Both hands or feet, the entire sight in both eyes, hearing in both ears, speech, one hand and one foot, one hand or foot and the entire sight of one eye	46 Months
One arm or leg	35 Months
One hand or foot	23 Months
The entire sight in one eye or hearing in one ear	15 Months

The loss of a hand or foot means the complete severance through or above the wrist or ankle joint. The loss of an arm or leg means complete severance through or above the elbow or knee joint. "Severance" means complete separation and dismemberment of the limb from the body. The loss of sight, speech or hearing means total and irrecoverable loss of the function.

If more than one loss results from an Accident, the Insurance Company will pay for the longest benefit period of the losses incurred.

Survivor Benefit

Amount of Benefit: 100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.

Maximum Benefit Period A single lump sum payment equal to 3 monthly Survivor Benefits.

Maximum Benefit Period

The later of the Employee's SSNRA* or the Maximum Benefit Period listed below.

<u>Age When Disability Begins</u>	<u>Maximum Benefit Period</u>
Age 62 or under	The Employee's 65th birthday or the date the 42nd Monthly Benefit is payable, if later.
Age 63	The date the 36th Monthly Benefit is payable.
Age 64	The date the 30th Monthly Benefit is payable.
Age 65	The date the 24th Monthly Benefit is payable.
Age 66	The date the 21st Monthly Benefit is payable.
Age 67	The date the 18th Monthly Benefit is payable.
Age 68	The date the 15th Monthly Benefit is payable.
Age 69 or older	The date the 12th Monthly Benefit is payable.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Initial Premium Rates

\$.28 per \$100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed \$16,667.

TL-004774

SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

For Employees hired on or before the Policy Effective Date:

The first of the month on or after 30 days continuous Full-time employment.

For Employees hired after the Policy Effective Date:

The first of the month on or after 30 days continuous Full-time employment

Definition of Disability/Disabled

The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is:

1. unable to perform the material duties of his or her Regular Occupation; and
2. unable to earn 80% or more of his or her Indexed Earnings from working in his or her Regular Occupation.

After Disability Benefits have been payable for 60 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is:

1. unable to perform the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of his or her Indexed Earnings.

The Insurance Company will require proof of earnings and continued Disability.

Definition of Covered Earnings

Covered Earnings means an Employee's wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include amounts received as bonus, commissions, overtime pay for more than 40 hours per week or other extra compensation. Monthly Covered Earnings will be figured by multiplying Covered Earnings by 4.333.

Any increase in an Employee's Covered Earnings will not be effective during a period of continuous Disability.

Elimination Period	180 days
Gross Disability Benefit	The lesser of 60% of an Employee's monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.
Maximum Disability Benefit	\$10,000 per month
Minimum Disability Benefit	\$100 per month

Disability Benefit Calculation

The Disability Benefit payable to the Employee is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month the Employee has no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Return to Work Incentive

During any month the Employee has Disability Earnings, his or her benefits will be calculated as follows.

The Employee's monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and the Employee has Disability Earnings:

1. Add the Employee's Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to the Employee's Indexed Earnings.
3. If the sum from 1. exceeds 100% of the Employee's Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. The Employee's Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of the Employee's Indexed Earnings, the Employee's Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she refuses to do so without Good Cause.

Additional Benefits

Catastrophic Disability Benefit

Amount of Benefit: 25% of an Employee's monthly Covered Earnings to a maximum monthly benefit of \$5,000.

Specified Loss Benefits

Time Period for Accident 90 days

Table for Accidental Loss

<u>Loss</u>	<u>Benefit Period</u>
Both hands or feet, the entire sight in both eyes, hearing in both ears, speech, one hand and one foot, one hand or foot and the entire sight of one eye	46 Months
One arm or leg	35 Months
One hand or foot	23 Months
The entire sight in one eye or hearing in one ear	15 Months

The loss of a hand or foot means the complete severance through or above the wrist or ankle joint. The loss of an arm or leg means complete severance through or above the elbow or knee joint. "Severance" means complete separation and dismemberment of the limb from the body. The loss of sight, speech or hearing means total and irrecoverable loss of the function.

If more than one loss results from an Accident, the Insurance Company will pay for the longest benefit period of the losses incurred.

Survivor Benefit

Amount of Benefit: 100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.

Maximum Benefit Period A single lump sum payment equal to 3 monthly Survivor Benefits.

Maximum Benefit Period

The later of the Employee's SSNRA* or the Maximum Benefit Period listed below.

Age When Disability Begins

Age 62 or under

Age 63

Age 64

Age 65

Age 66

Age 67

Age 68

Age 69 or older

Maximum Benefit Period

The Employee's 65th birthday or the date the 42nd Monthly Benefit is payable, if later.

The date the 36th Monthly Benefit is payable.

The date the 30th Monthly Benefit is payable.

The date the 24th Monthly Benefit is payable.

The date the 21st Monthly Benefit is payable.

The date the 18th Monthly Benefit is payable.

The date the 15th Monthly Benefit is payable.

The date the 12th Monthly Benefit is payable.

*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

Initial Premium Rates

\$.28 per \$100 of Covered Payroll

Covered Payroll for an Employee will mean his or her Covered Earnings for the insurance month prior to the date the determination is made. However, an Employee's Covered Payroll will not include any part of his or her monthly Covered Earnings which exceed \$16,667.

TL-004774

ELIGIBILITY FOR INSURANCE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date, or the day after he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed and within one year becomes a member of an eligible class.

TL-004710

EFFECTIVE DATE OF INSURANCE

An Employee will be insured on the date he or she becomes eligible, if the Employee is not required to contribute to the cost of this insurance.

If an Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to any occupation for the Employer on a Full-time basis.

TL-004712

TERMINATION OF INSURANCE

An Employee's coverage will end on the earliest of the following dates:

1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date the Employee is no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date the Employee is no longer in Active Service;
6. the date benefits end for failure to comply with the terms and conditions of the Policy.

Disability Benefits will be payable to an Employee who is entitled to receive Disability Benefits when the Policy terminates, if he or she remains disabled and meets the requirements of the Policy. Any period of Disability, regardless of cause, that begins when the Employee is eligible under another group disability coverage provided by any employer, will not be covered.

TL-007505.00

CONTINUATION OF INSURANCE

This Continuation of Insurance provision modifies the Termination of Insurance provision to allow insurance to continue under certain circumstances if the Insured Employee is no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the Termination of Insurance provisions.

Disability Insurance continues if an Employee's Active Service ends due to a Disability for which benefits under the Policy are or may become payable. Premiums for the Employee will be waived while Disability Benefits are payable. If the Employee does not return to Active Service, this insurance ends when the Disability ends or when benefits are no longer payable, whichever occurs first.

If an Employee's Active Service ends due to personal or family medical leave approved timely by the Employer, insurance will continue for an Employee for up to 12 weeks, if the required premium is paid when due.

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, insurance will continue for an Employee for up to 90 days, if the required premium is paid. An approved leave of absence does not include layoff or termination of employment.

If an Employee's Active Service ends for an Employee who is participating in the Exec-U-Flex program approved in writing by the Employer prior to the date the Employee ceases work, insurance will continue for an Employee for up to 1 year in case of severance, if the required premium is paid. An approved leave of absence does not include layoff or termination of employment.

If an Employee's Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer's reporting requirements for such short term absence, insurance for an Employee will continue until the earlier of:

- a. the date the Employee's employment relationship with the Employer terminates;
- b. the date premiums are not paid when due;
- c. the end of the 30 day period that begins with the first day of such excused absence;
- d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if an Employee's Active Service ends due to layoff, termination of employment, or any other termination of the employment relationship, insurance will terminate and Continuation of Insurance under this provision will not apply.

If an Employee's insurance is continued pursuant to this Continuation of Insurance provision, and he or she becomes Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date he or she is scheduled to return to Active Service.

TL-004716

TAKEOVER PROVISION

This provision applies only to Employees eligible under this Policy who were covered for long term disability coverage on the day prior to the effective date of this Policy under the Prior Plan provided by the Policyholder or by an entity that has been acquired by the Policyholder.

- A. This section A applies to Employees who are not in Active Service on the day prior to the effective date of this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of insurance. If required premium is paid when due, the Insurance Company will insure an Employee to which this section applies against a disability that occurs after the effective date of this Policy for the affected employee group. This coverage will be provided until the earlier of the date: (a) the employee returns to Active Service, (b) continuation of insurance under the Prior Plan would end but for termination of that plan; or (c) the date continuation of insurance under this Policy would end if computed from the first day the employee was not in Active Service. The Policy will provide this coverage as follows:
 1. If benefits for a disability are covered under the Prior Plan, no benefits are payable under this Plan.
 2. If the disability is not a covered disability under the Prior Plan solely because the plan terminated, benefits payable under this Policy for that disability will be the lesser of: (a) the disability benefits that would have been payable under the Prior Plan; and (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods and partial satisfaction of pre-existing condition limitations.

- B. The Elimination Period under this Policy will be waived for a Disability which begins while the Employee is insured under this Policy if all of the following conditions are met:
1. The Disability results from the same or related causes as a Disability for which monthly benefits were payable under the Prior Plan;
 2. Benefits are not payable for the Disability under the Prior Plan solely because it is not in effect;
 3. An Elimination Period would not apply to the Disability if the Prior Plan had not ended;
 4. The Disability begins within 6 months of the Employee's return to Active Service and the Employee's insurance under this Policy is continuous from this Policy's Effective Date.
- C. Except for any amount of benefit in excess of a Prior Plan's benefits, the Pre-existing Condition Limitation will not apply to an Employee covered under a Prior Plan who satisfied the pre-existing condition limitation, if any, under that plan. If an Employee, covered under a Prior Plan, did not fully satisfy the pre-existing condition limitation of that plan, credit will be given for any time that was satisfied under the Prior Plan's pre-existing condition limitation.

Benefits will be determined based on the lesser of: (1) the amount of the gross disability benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy.

If benefits are payable under the Prior Plan for the Disability, no benefits are payable under this Policy.

TL-005108

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits to each class of Insureds.

Disability Benefits

The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue.

Elimination Period

The Elimination Period is the period of time an Employee must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation

The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If an Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive

The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any month in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

The Insurance Company will, from time to time, review the Employee's status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit

The Insurance Company will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.

Other Income Benefits

An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by the Employee or his or her dependents under:
 - the Canada and Quebec Pension Plans;
 - the Railroad Retirement Act;
 - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
 - any sick leave or salary continuation plan of the Employer;
 - any work loss provision in mandatory "No-Fault" auto insurance.
2. any Social Security disability or retirement benefits the Employee or any third party receives (or is assumed to receive*) on his or her own behalf or for his or her dependents; or which his or her dependents receive (or are assumed to receive*) because of his or her entitlement to such benefits.
3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, the Insurance Company will pay for its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts received (or assumed to be received*) by the Employee or his or her dependents under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
6. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of an Employee's entitlement to benefits.

*See the Assumed Receipt of Benefits provision.

Increases in Other Income Benefits

Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating the Employee's Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments

Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits

The Insurance Company will assume the Employee (and his or her dependents, if applicable) are receiving benefits for which they are eligible from Other Income Benefits. The Insurance Company will reduce the Employee's Disability Benefits by the amount from Other Income Benefits it estimates are payable to the Employee and his or her dependents.

The Insurance Company will waive Assumed Receipt of Benefits, except for Disability Earnings for work the Employee performs while Disability Benefits are payable, if the Employee:

1. provides satisfactory proof of application for Other Income Benefits;
2. signs a Reimbursement Agreement;
3. provides satisfactory proof that all appeals for Other Income Benefits have been made unless the Insurance Company determines that further appeals are not likely to succeed; and
4. submits satisfactory proof that Other Income Benefits were denied.

The Insurance Company will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until the Employee actually receives them.

Social Security Assistance

The Insurance Company may help the Employee in applying for Social Security Disability Income (SSDI) Benefits, and may require the Employee to file an appeal if it believes a reversal of a prior decision is possible.

The Insurance Company will reduce Disability Benefits by the amount it estimates the Employee will receive, if the Employee refuses to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment

The Insurance Company has the right to recover any benefits it has overpaid. The Insurance Company may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to it.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.

If an overpayment is due when the Employee dies, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability

A separate period of Disability will be considered continuous:

1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, the Employee returns to work in his or her Regular Occupation for less than 6 consecutive months; and
3. if the Employee earns less than the percentage of Indexed Earnings that would still qualify him or her to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when the Employee is eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, the Employee must satisfy a new Elimination Period.

LIMITATIONS

Limited Benefit Periods for Mental or Nervous Disorders

The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Anxiety disorders
- 2) Delusional (paranoid) disorders
- 3) Depressive disorders
- 4) Eating disorders
- 5) Mental illness
- 6) Somatoform disorders (psychosomatic illness)

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Limited Benefit Periods for Alcoholism and Drug Addiction or Abuse

The Insurance Company will pay Disability Benefits on a limited basis during an Employee's lifetime for a Disability caused by any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid, no further benefits will be payable for any of the following conditions.

- 1) Alcoholism
- 2) Drug addiction or abuse

If, before reaching his or her lifetime maximum benefit, an Employee is confined in a hospital for more than 14 consecutive days, that period of confinement will not count against his or her lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-Existing Condition Limitation

The Insurance Company will not pay benefits for any period of Disability caused by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after an Employee is covered for at least 12 months after his or her most recent effective date of insurance, or the effective date of any added or increased benefits.

TL-007500.14

ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability

If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in a Rehabilitation Plan and assessment at our expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Insurance Company will work with the Employee, the Employer and the Employee's Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at the Insurance Company's discretion, allow for payment of the Employee's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

TL-007501.00

Catastrophic Disability Benefit

Definitions

The definitions that follow apply to this benefit provision. They are in addition to those definitions in the General Definitions section.

"Activities of Daily Living" are:

1. Bathing (i.e., washing oneself in a shower or tub, including getting into or out of the tub or shower, or washing oneself by sponge bath.)
2. Dressing oneself by putting on and taking off from one's own body all items of clothing and needed braces, fasteners and artificial limbs.
3. Continence (i.e., the ability to maintain control one's own bowel and bladder function; or when unable to maintain bowel or bladder function, the ability to perform associated hygiene, including caring for a catheter or colostomy bag).
4. Toileting oneself by getting to and from the toilet, getting on and off the toilet, and performing personal hygiene associated with toileting.
5. Feeding oneself by getting nourishment into the one's own body either from eating food that is made available to you in receptacle such as a plate, cup or table, or by feeding oneself by a feeding tube or intravenously.
6. Transferring (i.e., the ability to get oneself into or out of a bed, a chair or wheelchair; or the ability to move from place to place either by walking, use of a wheelchair, or some other means.

“Catastrophic Disability” means the Employee is:

1. Unable to perform, without Substantial Assistance, at least two Activities of Daily Living, or
2. Has a severe Cognitive Impairment that requires Substantial Supervision to protect the Employee or others from threats to health and safety.

“Cognitive Impairment” means the loss or deterioration in intellectual capacity that meets these requirements:

1. The loss or deterioration in intellectual capacity is comparable to and includes Alzheimer’s disease and similar forms of irreversible dementia;
2. The loss or deterioration in intellectual capacity is measured by clinical evidence and standardized tests that reliably measure impairment in the individual’s short-term and long-term memory, orientation as to person, place, or time and deductive or abstract reasoning.

“Substantial Assistance” means the physical assistance of another person without which the Employee would not be able to perform an activity of daily living; or the constant presence of another person within arm’s reach that is necessary to prevent, by physical intervention, injury to the Employee while the Employee is performing an activity of daily living.

“Substantial Supervision” means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is needed to protect the Employee from threats to health and safety.

Benefits Payable

Catastrophic Disability Benefits are payable when the Insurer determines that the Employee has a Catastrophic Disability that is due to the same sickness or injury for which Disability Benefits are payable under this Policy.

The benefits are payable only while these conditions are met:

1. The Employee is receiving monthly Disability Benefits under the Policy.
2. The Employee’s Catastrophic Disability lasted for at least the Elimination Period duration shown in the Schedule of Benefits.
3. The Employee submits, at his/her own expense, satisfactory proof of Catastrophic Disability to the Insurer, when required by the Insurer.

Amount Payable

Benefits are payable monthly at the Catastrophic Disability Rate shown in the Schedule of Benefits. This benefit will not be reduced by any other source of income.

For periods of less than one month, the Insurer will pay 1/30th of the monthly benefit for Catastrophic Disability for each day.

Termination of Benefits

Catastrophic Disability Benefits end on the earliest to occur of:

1. the date the Employee’s Catastrophic Disability ends;
2. the date the Employee is no longer receiving monthly disability benefits under the Policy;
3. the date the Employee fails to submit proof of continuing Catastrophic Disability; or
4. the date the Employee dies.
5. the end of the Maximum Benefit Period shown in the Schedule of Benefits.

No survivor benefits are payable for the Catastrophic Disability Benefit.

Specified Loss Benefit

If an Employee suffers a loss from an Accident, the Insurance Company will pay Disability Benefits as shown in the Table for Accidental Loss. For an Employee to be eligible for benefits, the following conditions must be met.

1. The loss must occur within the Time Period for Accident and must be shown in the Table for Accidental Loss.
2. The Accident must be the sole cause of the loss.
3. The Accident and the resulting loss must occur while coverage is effective.
4. The Elimination Period must be satisfied.

If an Employee dies within the Time Period for Accident, the Insurance Company will pay benefits for the period between the date Monthly Benefits are payable and the date the Employee dies. If the Employee dies after this time, but before the end of the Guaranteed Benefit Period, the Insurance Company will pay the rest in a lump sum.

"Accident" means a sudden, unforeseeable event that causes bodily injury to an Employee.

TL-005108

Survivor Benefit

The Insurance Company will pay a Survivor Benefit if an Employee dies while Monthly Benefits are payable. The Employee must have been continuously Disabled before the first benefit is payable. These benefits will be payable for the Maximum Benefit Period for Survivor Benefits.

Benefits will be paid to the Employee's Spouse. If there is no Spouse, benefits will be paid in equal shares to the Employee's surviving Children. If there are no Spouse and no Children, benefits will be paid to the Employee's estate.

"Spouse" means an Employee's lawful spouse. "Children" means an Employee's unmarried children under age 21 who are chiefly dependent upon the Employee for support and maintenance. The term includes a stepchild living with the Employee at the time of his or her death.

TL-005107

TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:

1. the date the Employee earns from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to him or her at that time;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date the Employee is no longer receiving Appropriate Care;
7. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

Extension of Benefits after Termination

Payment of Benefits will not be affected by termination of the Policy as long as the Disability begins while the Policy is in force.

TL-007502.14

EXCLUSIONS

The Insurance Company will not pay any Disability Benefits for a Disability that results directly from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane.
2. war or any act of war, whether or not declared.
3. active participation in a riot.
4. commission of a felony.
5. the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which the Employee is incarcerated in a penal or corrections institution.

TL-007503.14

CLAIM PROVISIONS

Notice of Claim

Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Claim Forms

When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision

Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data

The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss

Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, that the loss continues must be furnished to the Insurance Company at intervals required by us. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to the Insurance Company.

Time of Payment

Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which the Insurance Company is liable, will be paid at that time.

To Whom Payable

Disability Benefits will be paid to the Employee. If any person to whom benefits are payable is a minor or, in the opinion of the Insurance Company, is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, the Insurance Company may, at its option, make payment to the person or institution appearing to have assumed custody and support.

If an Employee dies while any Disability Benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following living relatives of the Employee: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of the Employee's estate. The Insurance Company may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Insurance Company from all liability for any payment made.

Physical Examination and Autopsy

The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship

The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 36 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Reporting Requirements

The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium

The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation

The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period

A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Reinstatement of Insurance

An Employee's insurance may be reinstated if it ends because the Employee is on an unpaid leave of absence.

An Employee's insurance may be reinstated only if reinstatement occurs within 12 weeks from the date insurance ends due to an Employer approved unpaid leave of absence or must be returning from military service pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For insurance to be reinstated the following conditions must be met.

1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. A written request for reinstatement must be received by the Insurance Company within 31 days from the date an Employee returns to Active Service.

Reinstated insurance will be effective on the date the Employee returns to Active Service. If an Employee did not fully satisfy the Eligibility Waiting Period or the Pre-Existing Condition Limitation (if any) before insurance ended due to an unpaid leave of absence, credit will be given for any time that was satisfied.

TL-004720

GENERAL PROVISIONS

Entire Contract

The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability

All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes

No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates

A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error

A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency

The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

TL-004726

Certain Internal Revenue Code (IRC) & Internal Revenue Service (IRS) Functions

The Insurer may agree with the Policyholder to perform certain functions required by the Internal Revenue Code and IRS regulations. Such functions may include the preparation and filing of wage and tax statements (Form W-2) for disability benefit payments made under this Policy. In consideration of the payment of premiums by the Policyholder, the Insurer waives the right to transfer liability with respect to the employer taxes imposed on the Insurer by IRS Regulation 32.1(e)(1) for monthly Disability payments made under this Policy. Employee money may not be used to fund the Premium for the services and payments of this section.

TL-009230.00

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Active Service

An Employee is in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. The Employee is performing his or her regular occupation for the Employer on a full-time basis. He or she must be working at one of the Employer's usual places of business or at some location to which the employer's business requires an Employee to travel.
2. The day is a scheduled holiday or vacation day and the Employee was performing his or her regular occupation on the preceding scheduled work day.

An Employee is in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Appropriate Care

Appropriate Care means the determination of an accurate and medically supported diagnosis of the Employee's Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Consumer Price Index (CPI-W)

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Disability Earnings

Any wage or salary for any work performed for any employer during the Employee's Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee

For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer

The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time

Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Good Cause

A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

Indexed Earnings

For the first 12 months Monthly Benefits are payable, Indexed Earnings will be equal to Covered Earnings. After 12 Monthly Benefits are payable, Indexed Earnings will be an Employee's Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:

1. 10% of the Employee's Indexed Earnings during the preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury

Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurability Requirement

An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company

The Insurance Company underwriting the Policy is named on the Policy cover page.

Insured

A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Policy after the Policy Effective Date.

Regular Occupation

The occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan

A written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

1. rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness

Any physical or mental illness.

TL-007500.14

SCHEDULE OF AFFILIATES

The following affiliates are covered under the Policy as of January 1, 2009.

Affiliate Name

Alexian Brothers Medical Center

St. Alexius Medical Center

Alexian Brothers Behavioral Health Hospital

Thelen

Bonaventure Medical Foundation

Workplace Solutions

Northwest Primary Care

Bonaventure Medical Group

Northwest Mental Health

TL-004776

IMPORTANT CHANGES FOR STATE REQUIREMENTS

If an Employee resides in one of the following states, the provisions of the certificate are modified for residents of the following states. The modifications listed apply only to residents of that state.

Louisiana residents:

The percentage of Indexed Earnings, if any, that qualifies an insured to meet the definition of Disability/Disabled may not be less than 80%.

Minnesota residents:

The Pre-existing Condition Limitation, if any, may not be longer than 24 months from the insured's most recent effective date of insurance.

Texas residents:

Any provision offsetting or otherwise reducing any benefit by an amount payable under an individual or franchise policy will not apply.

**LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235**

We, Alexian Brothers Health System, whose main office address is Arlington Heights, IL, hereby approve and accept the terms of Group Policy Number LK-961924 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA.

This form is to be signed in duplicate. One part is to be retained by Alexian Brothers Health System; the other part is to be returned to the LIFE INSURANCE COMPANY OF NORTH AMERICA.

Alexian Brothers Health System

Signature and Title: _____ Date: _____

(This Copy Is To Be Returned To LIFE INSURANCE COMPANY OF NORTH AMERICA)

**LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235**

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Alexian Brothers Health System

Signature and Title: _____ Date: _____

(This Copy Is To Be Retained By Alexian Brothers Health System)

NOTICE

This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:

Illinois Department of Insurance
Consumer Division or Public Services Section
Springfield, Illinois 62767

OR

Life Insurance Company of North America
Customer Advocate/Compliance Office
1601 Chestnut Street, TL16D
Philadelphia, PA 19192
Or via e-mail to: CGICustomerComplaints@cigna.com

EXHIBIT B

From:Melissa.Stout@Cigna.com

Sent:Wednesday, July 13, 2016 01:40:35 PM

To:lason\troy-prod-cemail

Cc:

Subject:FW: Document from MES (Claim Number : 2692932-02) IME

Melissa Stout, BSN, RN-BC
Nurse Case Manager Specialist

Cigna Group Insurance
P. O. Box 709015
Dallas, TX 75370-9015
1-800-352-0611 ext 4410
972-863-4410
Fax: 855-325-2981
Email: melissa.stout@cigna.com

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-----Original Message-----

From: Stout RN, Melissa 629
Sent: Wednesday, July 13, 2016 12:22 PM
To: Aguilar, Silvia 629
Subject: FW: Document from MES (Claim Number : 2692932-02) IME

Melissa Stout, BSN, RN-BC
Nurse Case Manager Specialist

Cigna Group Insurance
P. O. Box 709015
Dallas, TX 75370-9015
1-800-352-0611 ext 4410
972-863-4410
Fax: 855-325-2981
Email: melissa.stout@cigna.com

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-----Original Message-----

From: Diana Van Winkle [mailto:Diana.VanWinkle@mcsgroup.com]
Sent: Tuesday, July 12, 2016 12:59 PM
To: Vendor Medical
Subject: Document from MES (Claim Number : 2692932-02)

Please note the attached document for your review regarding H STANO, your client file:2692932-02, Our Case: 21516004881-0.

Feel free to contact us with any questions or concerns

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Mid America Medical Center
639 W. North Avenue
Villa Park, IL 60181
630-516-0960 Fax 630-516-0951

July 5, 2016

MES Solutions
299 Market Street
Suite 100
Saddlebrook, NJ 07663

Claimant: H Stano
Claim #: 2692932-02

Dear Sir/Madam:

At your request on June 30, 2016, I examined Ms. Stano at this office. I obtained the history from the Claimant as well as from review of records provided with the request. These records include physician progress notes, social security medical evaluation reports, diagnostic imaging study reports, lab test results, chiropractic examination reports, specialist notes, several peer review notes and other relevant records. These are the types of medical records customarily relied upon by physicians.

History of present Illness and Course of Condition:

Ms. Stano states that her problem started around 2007/2008 with severe back pain that was described as 10/10 on the pain scale at times. She states that she underwent some physical therapy as well as some chiropractic examinations and treatments. She also underwent X-rays and CT scan that showed that she has severe disc disease in the lumbar spine. After being treated for several weeks, her pain improved and she was able to return to work full duty.

In 2010 claimant states that she developed multiple joint pain and stiffness involving both hips, knees, and shoulders in addition to her worsening lower back pain. She underwent physical therapy and started using a back belt for support and continued to work, but the pain continued to worsen over time.

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Claimant states that several blood tests at the time showed gradually increasing positive rheumatoid factor. She was diagnosed with rheumatoid arthritis and spondyloarthropathy.

She states that she was tried on methotrexate but she could not tolerate its side effects. She was also giving several other kinds of medicine including tramadol and ketoprofen. Claimant states that she also developed prolapse of both her uterus and urinary bladder which became gradually worse with time and had to undergo pessary insertion and that she suffered from urinary incontinence.

Claimant also states that she developed grinding shoulders, weakness to both arms, inflammation affecting her vision and causing severe dizziness.

She is under the care of a primary physician and a rheumatologist.

Current Complaints:

At present claimant complains of constant low back pain, multiple and bilateral joint pain and stiffness involving both hips, both shoulders, both knees and both wrists. She also complains of being tired all the time, insomnia, inability to concentrate, having problems holding objects, also problems with her balance.

Occupational History:

Claimant states that she worked as a cardiac nurse at Alexian Brothers Hospital in Elk Grove Village IL for 26 years. She discontinued working in 2012 due to worsening pain. She was also advised not to return to work by her treating physician. She has not returned to work since that time.

Usual Daily Activities:

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Claimant: H Stano
Claim #: 2692932-02

Claimant states she would wake up feeling tired and stiff. She takes her time getting off the bed which takes up to 15 minutes at times, and then she would start to do stretching exercises lasting up to half an hour. She would then make simple breakfast and occasionally she would try to walk about 1/2 a block outside then would return and lay down or take a nap. She reads newspapers and sometimes has coffee with friends who come over or she would meet them outside. She goes grocery shopping at a nearby store and tries to do minor house chores but her sister would come over and help as well.

At present, claimant states that her goal is to maintain her health, to be as functional and independent as possible as she lives alone. She hopes that one day she might get better but she knows she has to deal with frequent flare ups.

Medical Records Review:

Available records include a note dated 10/8/2012 by Dr. Thomas Palella stating that Ms. Stano is currently incapacitated by her arthritis and cannot return to work. A medical report dated 5/9/13 by Dr. Roopa Karri an internist which was done for the Bureau of Disability Determination Services noted that claimants grip strength was 3/5 in both hands and has limited range of motion of her shoulders as well as her knees.

Several peer reports were reviewed and they were dated 2015 at different times. In the report dated 11/15/15 the following imaging findings were reported: diffuse degenerative changes in the lumbar spine from an MRI dated 12/29/2011 with spinal stenosis and foraminal narrowing. Also degenerative changes at L4-L5. A lab report with positive HLA-B27 dated 7/7/2012, a lab report dated 5/21/13 with positive rheumatoid factors which was repeated as positive several times later. An X-ray of the left knee dated 2/5/2015 showing moderate osteoarthritic changes.

A note signed by Dr. Monica Rolek dated 12/19/2014 states claimant was suffering from poor sleep and attention span, also poor balance, cognitive impairment, depressed mood, stress reactivity and

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medication/environmental sensitivities. A note dated 2/5/2015 from Centegra Health System from Ali Malick, indicating that the rheumatoid factor went up from 114 to 203. It also quotes an MRI finding of near complete loss of intervertebral disc space height consistent with severe intervertebral disc degenerative disease at L5-S1 with severe facet hypertrophy, degenerative changes bilaterally resulting in severe right foraminal stenosis, moderate left stenosis and severe central canal stenosis.

Above findings are consistent with an MRI report of the lumbar spine dated 12/29/2011 in which it shows diffuse degenerative changes with spinal stenosis and foraminal narrowing in the lower lumbar spine most notably L4-L5 and L5-S1.

With regards to lab test results dated 7/23/2012 showing positive HLA-B27 and another test dated 11/10/2014 showing rheumatoid factor positive at 203 (normal less than 15) with normal CPR. Another test dated 4/9/2014 showing TSH at 0.12 which is low. A note from Rockford Orthopedic by Dr. Andrew Jasek lists diagnosis rheumatoid arthritis, spondyloarthropathy, plantar fasciitis, and Achilles bursitis.

A blood test dated 2/10/15 showed rheumatoid factor more than 320 (normal is less than 15).

An X-ray of both hips dated 2/5/15 showed minimal degenerative changes of the right hip and mild to moderate changes to the left hip.

X-ray of both knees at the same day show narrowing of the medial compartment bilaterally.

An independent peer review report dated 8/17/2015 and signed by Dr. Mark Burns stated that there are no restrictions from a rheumatologic viewpoint after record reviews and no impairments were documented.

Finally a list of medications included Synthroid, Limbrel 250 mg once a day, Vitamin D, Lidoderm Patch in addition to Calcium, Aleve and other supplements.

Past Medical History:

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Claimant: F Stano
Claim #: 2692932-02

History of Hypothyroidism and elevated Cholesterol.

Allergies:

Levaquin and Aspirin.

Surgical History:

None

Medication:

Limbrel, Synthroid, Lidoderm Patch, Aleve, Calcium, Omega 3 and Glucosamine.

Social History:

Claimant lives by herself. Denies tobacco or alcohol use.

Family History:

Parents deceased history of Cancer.

Physical Examination:

Claimant arrived by herself, she drove her own car. She walked into the office unassisted, but with a slow, stiff and cautious gait. She appears at stated age, properly attired, cooperated with the evaluation and was in a flat and sometimes depressed mood. She was alert and oriented and in no distress.



Vital Signs: Weight 168lbs, Height 67 inches, Blood pressure 110/80, Pulse 60.

Head and Neck Examination:

Atraumatic, Normocephalic, Eyes: PERRLA, EOML. Clear throat and ears. Neck showed marked stiffness with limitation of range of motion in all axes.

Musculoskeletal Examination:

Upper extremities: no apparent joint deformities, swelling or effusions however, there is limitation to both shoulders range of motion abduction: 80/180, forward flexion: 110/180 with lateral rotation diminished 50% bilaterally. There is normal range of motion of both elbows and wrist. Motor strength 4/5 bilaterally including hand grip and finger pinch.

Lower Extremities:

No swelling, scarring or deformities, there is normal hip range of motion bilaterally with some subjective discomfort left more than right. Both knees exhibit moderate stiffness with range of motion 0 to 100 degrees bilaterally due to discomfort. Normal ankle range of motion bilaterally with no swelling or abnormal findings. Motor strength 4/5 bilaterally.

Deep Tendon Reflexes:

2 plus and symmetric. 1+ Knees reflexes bilaterally.

Spine:

Moderate stiffness with para-spinal tenderness noted. Straight leg raising test associated with low back pain bilaterally at 60 degrees. Spinal range of motion flexion: 60/90 with marked moderate discomfort,

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Claimant: F Stano
Claim #: 2692932-02

extension: 20/35, lateral-rotation: 20/40 with marked stiffness. Claimant did tandem walking which was slow. Attempted to walk on toes and heels but was unsuccessful due to imbalance and the need to hold on to objects.

Chest:

Symmetric, normal breathing movements.

Lungs:

Clear to auscultation bilaterally.

Heart:

Normal S1, S2, RRR.

Abdomen:

Soft, non-tender, no organomegaly.

Neurological:

Cranial nerves II-XII grossly intact.

Gait:

Stiff and slow.

Impression/Conclusion:

Ms. Stano is a 64 year old female who worked as a cardiac nurse at Alexian Brothers Hospital for 26 years. Several years ago, she developed low back pain followed by multiple joint pain and stiffness. She



was found to have severe degenerative changes with foraminal narrowing and spinal stenosis mostly involving L4-5 and L5-S1. She was also diagnosed with rheumatoid arthritis with an elevated rheumatoid factor as described and a positive HLA-B27. However, her CRP-Inflammation were consistently negative. She complains of severe low back pain, pain of both shoulders, hips, knees and stiffness with limitation to range of motion. Her examination today concluded negative distraction and Wadell signs indicating no suspicion of symptom magnification. Claimant also suffers from hypothyroidism as well as severe uterine and urinary bladder prolapse. She also complains of lack of concentration, chronic fatigue, insomnia, imbalance problems. She is currently under the care of a primary care physician as well as a rheumatologist.

Answer to Questions:

1. Based on your examination and review of the provided records is H Stano physically functionally impaired from December 11, 2014 and ongoing? Describe in full and enumerate the specific observations, examination findings, diagnostic tests and functional assessments demonstrating the impairment and its extent.

Are work activity restrictions medically necessary; enumerate these and indicate if they are based in your professional experience, the consensus opinion of a professional body (identify), and /or scientific literature (provided citations)?

Ms. Stano in my opinion is physically functionally impaired from December 11, 2014 and ongoing. Although her condition seems to have been somewhat stabilized during that period, she continues to suffer from severe lower lumbar spine degenerative disease mostly at L4-5 and L5-S1 with severe spinal stenosis and foraminal narrowing as evidenced by several MRI reports.

Also multiple joint pain, stiffness and limitation to range of motion mostly involving both shoulders, and knees and to a lesser extent both hips, with diagnosis of rheumatoid arthritis with

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Claimant: H Stano
Claim #: 2692932-02

positive rheumatoid factor causing her severe stiffness in gait and movement. She also has significant weakness to both upper and lower extremities as evidenced by her examination today.

Work restrictions would be medically necessary as claimant cannot sit and/or stand more than 10-15 minutes, must change positions frequently, with limitations to her lifting, carrying, pushing, pulling and other maneuvers as detailed in the physical abilities assessment form. This opinion is based on my professional experience, my review of medical records and today's examination.

- 2. Does H Stano have any functional limitations or cognitive issues resulting from medication side effects.

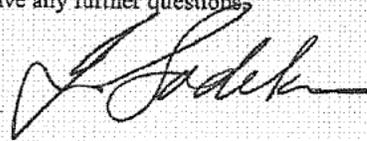
It is my opinion that Ms. Stano has no functional limitations or cognitive issues resulting from medication side effects

- 3. Complete the enclosed Physical Abilities Assessment Form. Provided clinical detail in your narrative report to support any restrictions that you note on this form. Note that it is critical that the narrative portion of your report that addresses work capabilities precisely match the Physical Abilities Assessment Form.

Please refer to the attached completed Physical Abilities Assessment Form.

Please do not hesitate to contact this office should you have any further questions.

Sincerely, Ibrahim S. Sadek, M.D. MPH



Board Certified, Occupational Medicine License 036083-348 IL.

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Physical Ability Assessment

Life Insurance Company of North America
 Connecticut General Life Insurance Company
 Cigna Life Insurance Company of New York
 Great-West Healthcare Administered by Cigna



We are evaluating a disability claim for our customer and need to determine functional impairment. Please check the boxes corresponding to his/her level of physical functioning. Please submit any and all medical documentation, including documented observations, physical exam findings and functional assessments. We appreciate your prompt response to this request.

Customer Name H Stano Date of Birth 6/3/1952
 Diagnosis(es)/ICD-9 Code/ICD-10 Code 715.90 (MSI.36) - 714.0 (M06.9)

Your assessment of our customer's physical abilities is based on (check all that apply):

- Customer's report
- Observation
- Examination
- Your functional assessment
- A formal functional capacity evaluation (FCE)
- A diagnosis that implies an increased risk of harm requiring physician imposed work activity restrictions

Date of physical examination, or date of last office visit, on which your assessment of physical abilities is based _____

Throughout an 8-hour workday, to the extent that positional changes are necessary, with rest breaks and meal breaks at appropriate intervals, he or she can tolerate the following activities for the specified durations:

	Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: 0 - 2.5 Hrs/Day 0 - 1/3 of the Day	Check if supported by clinical findings	Does Not Apply to Diagnosis
Sitting:		✓			
Standing:			✓		
Walking:			✓		
Reaching: Overhead			Notable		
Desk Level		✓			
Below Waist			✓		
Fine Manipulation: Right:		✓			
Left:		✓			
Simple Grasp: Right:		✓			
Left:		✓			
Firm Grasp: Right:			Notable		
Left:					

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	Constantly: > 5.5 Hrs/Day > 2/3 of the Day	Frequently: 2.5 - 5.5 Hrs/Day 1/3 - 2/3 of the Day	Occasionally: 0 - 2.5 Hrs/Day 0 - 1/3 of the Day	Check If supported by clinical findings	Does Not Apply to Diagnosis
Lifting:					
Negligible Amount- 10 lbs.			✓		
11-20 lbs.					
21-50 lbs.					
51-100 lbs.					
100+ lbs.					
Carrying:					
Negligible Amount- 10 lbs.			✓		
11-20 lbs.					
21-50 lbs.					
51-100 lbs.					
51-100 lbs.					
Pushing: (Max. Wt.: <u>10</u>)			✓		
Pulling: (Max. Wt.: <u>10</u>)					
Climbing: Regular Stairs			<i>Notable</i>		
Regular Ladders					
Balancing:			—		
Stooping:			—		
Kneeling:			—		
Crouching:			—		
Crawling:			—		
Seeing:	✓				
Hearing:	✓				
Use lower extremities for foot control			✓		
Other: _____					

Please use this space to elaborate on any of the above categories including environmental conditions or the work environment:

Unable to sustain firm grasp due to Bilateral upper extremities weakness

Name: IBRAHIM S SADEK
 Medical Specialty: Occupational Medicine
 Address: 639 W. North Ave, Villa Park, IL 60181
 Federal ID tax number: 364171807

Signature: *Ibrahim Sadek*
 Date: 6/30/2016
 Phone: 630-516-0960



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[The following text is extremely faint and largely illegible due to low contrast and scan quality. It appears to be a list or table of items, possibly related to a legal case or inventory.]

[This section contains additional faint text, likely a continuation of the list or table from the upper section. The content is mostly illegible.]

[Vertical text on the right margin, possibly a page number or reference code.]