BlueCross BlueShield of Texas

Voluntary Long Term Disability Insurance

Employee Benefit Booklet

THE UNIVERSITY OF TEXAS SYSTEM

GFZ71778-0001

Class 1-01

08/19/2021

Dearborn Life Insurance Company

Group Certificate

Dearborn Life Insurance Company

Chicago, Illinois

Administrative Office: 701 E. 22nd Street • Lombard, IL 60148

Having issued Group Policy No. **GFZ71778-0001**

(herein called the Policy or this Plan)

to

The University of Texas System

(herein called the Policyholder)

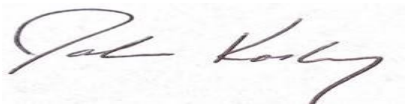
CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, become insured and remain insured in accordance with the terms of the Policy. *Your* insurance is subject to all the definitions, limitations and conditions of the Policy. It takes effect on the effective date stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This certificate describes *Your* eligibility for benefits and the terms and provisions of the Policy. It replaces and cancels any other certificate previously issued to *You* under the Policy.

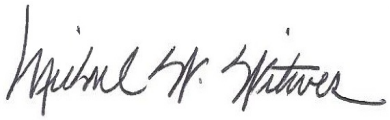
If the terms and provisions of the Certificate of Coverage (issued to *You*) are different from the policy (issued to the *Policyholder*), the Policy will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company



Secretary



President

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Group Voluntary Long-Term Disability Certificate

Participating

TABLE OF CONTENTS

Note: All terms in *Italics* are listed and defined in the Definitions section or within the certificate itself.

SCHEDULE OF BENEFITS

Policyholder:	The University of Texas System	
Policy Number:	GFZ71778-0001	
Effective Date:	September 1, 2009 (Revised September 1, 2021)	
Annual Enrollment:	July 15 – July 31	
Eligibility:	The following are eligible: All active benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment excluding those individuals who are covered under another group disability program provided by the Medical Practice Plan (MSRDP/PRS) Benefits.	
Waiting Period:	If *You* are in a class eligible for insurance: The date of hire or the first day of the month following the date of hire, whichever *You* elect when *You* enroll.	
Elimination Period:	90 Days	
Elimination Period for Catastrophic Disability Benefit	90 Days	
LTD Monthly Benefit:	60% of *Monthly Earnings* to a *Maximum Gross Monthly Benefit* of $15,000.00 per month subject to reduction by deductible sources of income or *Disability Earnings*	
Social Security Offset Method:	Family Social Security	
Policyholder Contribution:	0% of premium	
Maximum Period Payable:	**Age on *Date of Disability***	**Maximum Period Payable**
	Less than 60	To age 65, but not less than 60 months
	60 – 64	60 months
	65 – 69	To age 70, but not less than 12 months
	70 and over	12 months
Maximum Period Payable for Catastrophic Disability Benefit:	**Age on *Date of Disability***	**Maximum Period Payable**
	Less than 60	To age 65, but not less than 60 months
	60 – 64	60 months
	65 – 69	To age 70, but not less than 12 months
	70 and over	12 months

OTHER FEATURES

The following other features are included:

- Waiver of Premium
- Work Incentive Benefit
- Rehabilitation Incentive Income
- Day Care Expense Benefit
- Education Benefit
- Recurrent Disability
- FMLA Coverage Extension
- Conversion Privilege
- Survivor Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- Catastrophic Disability Benefit
    - Caregiver Respite Benefit
    - Caregiver Training Benefit
    - Emergency Alert System Benefit
- Accidental Dismemberment Benefit
- Continuity of Coverage

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.

ELIGIBILITY AND EFFECTIVE DATES

Who is eligible for this insurance?

The following people are eligible: All active benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment excluding those individuals who are covered under another group disability program provided by the Medical Practice Plan (MSRDP/PRS) Benefits.

The *Waiting Period* is shown in the *Schedule of Benefits.*
00001 UTS

When does Your Contributory insurance become effective?

Your Contributory coverage will become effective on the latest of the following dates, provided *You* are *Actively at Work* on that date:

1. If there is no *Waiting Period*, the date you are eligible for coverage, if *You* enroll for coverage on or before that date;
2. If *You* sign the *Enrollment Form* after the end of the *Waiting Period*, but within 31 days after that day, *Your* coverage will become effective the date *You* are eligible for coverage.
3. If *You* do not sign the *Enrollment Form* within this 31-day period, *You* will be considered a late entrant and must wait until the next *Annual Enrollment* to apply for coverage, unless *You* qualify because of a *Change in Family Status*.
    a. Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment* period will become effective on the Policy anniversary date.
    b. Coverage because of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date of the *Change in Family Status* event.

You must be *Actively at Work* for coverage under the Policy to become effective. If, because of *Injury* or *Sickness*, *You* are not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.

Contributory means *You* pay all or a portion of the premium for this insurance coverage.

Enrollment Form means the application *You* complete to apply for coverage under the Policy.
00003 UTS

Change in Family Status

If *You* experience a qualified *Change in Family Status*, *You* may enroll for *Contributory* coverage, apply for additional coverage, or request changes to *Your* current *Contributory* benefit program(s) without providing *Evidence of Insurability*. *You* must submit the appropriate *Enrollment Form* within 31 days of the *Change in Family Status*.
00004 UTS

Change in Family Status means changes in the status of *Your* family, including but not limited to:

1. *You* get married;
2. *You* have a dependent child, or *You* adopt or become the legal guardian of a dependent child;
3. *Your Spouse* dies or *You* become divorced;
4. *Your* dependent child becomes emancipated or dies;
5. *Your Spouse* is no longer employed, resulting in a loss of group insurance, or;
6. *You* have a change in classification which results in *You* changing from part-time to full-time, or full-time to part-time.

00004-A

What happens if* You *take a leave of absence?

You have two options if *You* take a leave of absence:

1. *You* may continue *Your* coverage for the period of the leave of absence provided *Your* premium is paid; or

2. *You* may terminate *Your* coverage effective the date *Your* leave of absence begins.

If *You* continue *Your* coverage and return to work on the first work day following the end of *Your* leave of absence, *Your* coverage will continue.

If *You* do not return to work on the first work day following the date *Your* leave of absence ends, *Your* coverage will terminate on the date *Your* leave of absence ended.
If *You* terminate *Your* coverage when *Your* leave of absence begins or before the end of the approved leave of absence period, *You* must re-enroll when *You* return to work after a leave of absence. *Evidence of Insurability* is required if *You* do not re-enroll within 31 days of returning to work after a leave of absence.
00098 UTS

When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late entrant, which means *You* enroll for insurance more than 31 days after the date *You* are eligible for insurance; or

2. *You* voluntarily canceled *Your* insurance and are reapplying.

You may obtain an *Evidence of Insurability Form* from *the Policyholder*.
00005

Changes to Your coverage

A change in *Your* coverage may occur if there is a Policy change. If *You* are eligible for additional coverage due to a Policy change, the additional coverage will be effective on the date the Policy change is effective, as requested by the Policyholder and agreed upon by *Us*.

In order for *Your* additional coverage to begin, *You* must be in *Actively at Work*. Additional coverage is subject to payment of premium.

Additional coverage includes increases in *Your Monthly Benefit* amount and other benefit provisions that may impact when or for how long benefits are payable. Additional coverage is subject to the *Pre-Existing Condition* Exclusion.

Any decrease in coverage will take effect immediately. If the *Date* of *Disability* was prior to the decrease, any claim resulting from that *Disability* will be paid at the amount in effect at the time the Disability was incurred.
00006

Evidence* of *Insurability means a statement of *Your* medical history which *We* will use to determine if *You* are approved for coverage. *Evidence of Insurability* will be provided at *Our* expense.

Evidence of Insurability Form means a form provided or approved by Us on which you provide a statement of your medical history.
00007

What is an Annual Enrollment period?

Unless otherwise specified, *Annual Enrollment Period* means the period of time prior to the Policy anniversary date. *Your Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Eligible Employees may enroll in the Plan, apply for additional coverage, or request changes to their current Voluntary Benefit program(s) only during the *Annual Enrollment*, unless they qualify because of a *Change in Family Status*. Employees hired after an *Annual Enrollment* period may enroll within 31 days following their eligibility date. If a new Employee does not elect Voluntary coverage within that time period, he must wait for the next the *Annual Enrollment* to enroll unless they qualify because of a *Change in Family Status*.

Initial requests for coverage or requests for changes to existing coverage made during the *Annual Enrollment* period will become effective on the Policy anniversary date or the date *We* determine *Evidence of Insurability* is satisfactory and *We* provide written notice of approval, whichever is later.
00099 UTS

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.
00008

Do You have to pay premium while You receive benefits?

We will waive premium for *You* during a period of *Disability* for which the *LTD Monthly Benefit* is payable under the Policy. Premium payment is required during *Your Elimination Period* or any other period when the *LTD Monthly Benefit* is not payable under the Policy**.**
00009

What happens if We are replacing an existing Policy? (Continuity of Coverage)

Effect on Actively at Work requirement

If *You* were insured under the *Prior Policy* on the day before the Policy Effective Date, *You* may be covered by the Policy even if *You* do not satisfy the *Actively at Work* requirement as stated in the *When does insurance become effective?* provision and *You* would otherwise be eligible to become insured under the Policy, *We* will provide limited coverage under this Plan. Coverage under this provision will begin on the Policy effective date and will continue until the earliest of:

1. The end of the month following the date *You* become *Actively at Work*;
2. The end of any period of continuance or extension provided under the *Prior Policy*; or
3. The date coverage would otherwise end, according to the provisions of the Policy.

Your coverage under this provision is subject to payment of premium.

Effect on Benefits

If *You* do not satisfy the *Actively at Work* requirement, *You* may still be eligible for benefits under the Policy as follows:

The benefits payable under the Policy will be the benefits which would have been payable under the terms of the *Prior Policy* if it had remained in force; and the benefits payable under the *Policy* will be reduced by any benefits payable under the *Prior Policy* for the same *Disability* for which the prior carrier is liable.

The ***Prior Policy*** is the group disability insurance policy issued to the Policyholder by Hartford Life Insurance Company whose coverage terminated immediately prior to the Policy Effective Date.

Effect on Pre-existing Conditions

If *You* have a *Disability* due to a *Pre-Existing Condition* after the *Prior Policy* has been replaced by this Plan, Benefits may be payable if:

1. *You* were insured under the *Prior Policy* at the time the Policyholder changed coverage from the *Prior Policy* to the Policy; and
2. *You* have been continuously insured under this Plan from the effective date of this Plan until the date *Your Disability* began.

In order for benefits to be paid, *You* must satisfy the *Pre-Existing Condition* exclusion under:

1. this Plan; or
2. the *Prior Policy*, if benefits would have been paid had the Prior Policy remained in force.

If *You* satisfy the *Pre-Existing Condition* exclusion of this Plan, *We* will determine *Your* payments according to this Plan's provision.

If *You* do not satisfy the *Pre-Existing Condition* exclusion of this Plan, but *You* do satisfy the *Pre-Existing Condition* provision under the *Prior Policy*:

1. *Your Monthly Benefit* will be the lesser of:
    a. The *Monthly Benefit* that would have been payable under the terms of the *Prior Policy* if it had remained in force; or
    b. The *Monthly Benefit* under this Plan.
2. Benefits will end on the earlier of:
    a. The date benefits end under the Policy, as described under the Maximum Period Payable; or
    b. The date benefits would have ended under the *Prior Policy* if it had remained in force.

If *You* do not satisfy the *Pre-Existing Condition* exclusion under either this Plan or the *Prior Policy*, *We* will not make any payments.

We will require proof that *You* were insured under the *Prior Policy*.
00010

Eligibility after You Terminate Employment

If *Your* coverage ends due to termination of employment, *You* must meet all the requirements of a new *Employee* if *You* are rehired at a later date.

Exception: If *Your* coverage ends due to termination of employment and you return to *Active Work* in an eligible class within 6 months days, we will not:

1. apply a new *Eligibility Waiting Period*;
2. apply a new *Pre-existing Condition Exclusion;*
3. require *Evidence of Insurability*.

00100 UTS

LONG-TERM DISABILITY BENEFITS

How do We define Total Disability?

If the institutions are in session, Total Disability or Totally Disabled means that during the first 24 consecutive months of benefit payments due to Sickness or Injury:

1. You are continuously unable to perform the Material and Substantial Duties of Your Regular Occupation, and
2. Your Disability Earnings, if any, are less than 20% of Your pre-disability Indexed Monthly Earnings.

After the LTD Monthly Benefit has been paid for 24 consecutive months, Total Disability or Totally Disabled means that due to Injury or Sickness:

1. You are continuously unable to engage in any Gainful Occupation, and

2. Your Disability Earnings, if any, are less than 20% of Your pre-disability Indexed Monthly Earnings.

If the institutions are not in session, Total Disability or Totally Disabled means that during the first 24 consecutive months of benefit payments due to Sickness or Injury:

1. You would be continuously unable to perform the Material and Substantial Duties of Your Regular Occupation, and

2. Your Disability Earnings, if any, would be less than 20% of Your pre-disability Indexed Monthly Earnings.

After the LTD Monthly Benefit has been paid for 24 consecutive months, Total Disability or Totally Disabled means that due to Injury or Sickness:

1. You would be continuously unable to engage in any Gainful Occupation, and

2. Your Disability Earnings, if any, would be less than 20% of Your pre-disability Indexed Monthly Earnings.
00013 UTS

How do We define Partial Disability?

If the institutions are in session, Partial Disability or Partially Disabled means that during the Elimination Period and Maximum Benefit Period, due to Injury or Sickness, You are working in any Gainful Occupation and you are able to earn Disability Earnings of at least 20% of Your pre-disability Indexed Monthly Earnings but are unable to earn more than 80% of Your pre-disability Indexed Monthly Earnings.

If the institutions are not in session, Partial Disability or Partially Disabled means that during the Elimination Period and Maximum Benefit Period, due to Injury or Sickness, You would be able to earn Disability Earnings of at least 20% of Your pre-disability Indexed Monthly Earnings but would be unable to earn more than 80% of Your pre-disability Indexed Monthly Earnings.
00014 UTS

Loss of Professional License or Certification

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability*.
00017

What is the Elimination Period and how is it satisfied?

The *Elimination Period* is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. It is shown in the *Schedule of Benefits* and begins on *Your Date of Disability*.

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than or equal to one-half the Elimination Period rounded up to the next whole number, not to exceed 45 days. The days that *You* are not *Disabled* will not count toward *Your Elimination Period*.

If *You* return to work for a period greater than one-half the Elimination Period, or 90 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period*.
00018

Can You satisfy Your Elimination Period if You are working?

You can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.
00019

What Disability Benefit are You eligible to receive?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1. an *LTD Monthly Benefit*; or

2. a Work Incentive Benefit.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
00020 UTS

What is Your LTD Monthly Benefit and how is it calculated?

Your LTD Monthly Benefit will be based on *Your Monthly Earnings* as reported to *Us* by the *Policyholder* and for which premium has been paid.

An *LTD Monthly Benefit* will be payable after the end of the *Elimination Period* if *You* are *Disabled. We* will calculate *Your Gross LTD Monthly Benefit* amount as follows:

1. Multiply *Your Monthly Earnings* by 60%
2. The maximum *Gross LTD Monthly Benefit* is $15,000.00.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit.*
4. *Subtract the Deductible Sources of Income from Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.
5. Compare the answer from item 3 and 4.

The lesser amount figured in item 5 is *Your Monthly Benefit.*

If a benefit is payable for less than one month, it will be paid on the basis of 1/30th of the *Net LTD Monthly Benefit* for each day of *Disability*.
00021-B UTS

How do We define Monthly Earnings?

Monthly Earnings will equal the greater of:

1. 1/12th of *Your* the last reported gross annual income from *Your Employer* on day immediately prior to *Your Date of Disability*.
2. 1/12th of *Your* gross annual income from *Your Employer* in effect on the September 1 immediately prior to *Your Date of Disability*.

It includes:

1. hazardous duty pay;
2. longevity pay;
3. employee contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee Retirement Plan or deferred compensation arrangement; and
4. amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:

1. commissions;
2. bonuses;
3. overtime pay; or
4. *Your* Employer's contribution on *Your* behalf to a Retirement Plan or deferred compensation arrangement; or
5. any other extra compensation.

00022 UTS

What are the Deductible Sources of Income?

1. *Disability* benefits paid, payable, or for which *You* are eligible under:
   a. The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;

b. Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational Injury or Sickness;

c. Occupational accident coverage provided by or through the *Policyholder*;

d. Any Statutory Disability Benefit Law;

e. The Railroad Retirement Act;

f. The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;

g. The Canada Old Age Security Act;

h. Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans;

i. Title 46, United States Code Section 688 et seq (The Jones Act);

j. Title 33, United States Code Section 901 et seq (Longshore and Harbor Workers' Compensation Act).

2. *Disability* benefits paid, payable, or for which You are eligible under:

   a. Any group insurance plan provided by or through the Policyholder, and

   b. Any sick leave or salary continuance plan provided by or through the *Policyholder*.

3. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;

4. Retirement and *Disability* benefits paid under a Retirement Plan provided by the *Policyholder* except for amounts attributable to *Your* contributions;

5. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;

6. Amounts received from a third party after subtracting attorney's fees by judgment, settlement or otherwise, not to exceed 50% of the net settlement.

Proration of Lump Sum Awards

If any Deductible Source of Income described above is paid in a single sum through compromise settlement or as an advance on future liability, *We* will determine the amount of reduction to *Your Gross LTD Monthly Benefit* as follows:

1. *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or

2. If the number of months for which the settlement or advance is made is not known, *We* will divide the amount of the settlement or advance by the expected remaining number of months for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 60 months.

What other sources of income are not deductible?

We will not reduce *Your Gross LTD Monthly Benefit* by any of the following:

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;

2. credit disability insurance;

3. pension plans for partners;

4. military pension and disability income plans;

5. franchise disability income plans;

6. individual disability income plans;

7. a *Retirement Plan* from another *Policyholder*;

8. profit sharing plans;

9. thrift or savings plans;

10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan;
13. vacation pay.

00023 UTS

Can You work and still receive benefits?

While *Disabled, You* may qualify for the Work Incentive Benefit.

Work Incentive Benefit

A Work Incentive Benefit will be payable if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *LTD Monthly Benefits*.

The Work Incentive Benefit will be calculated during the first 24 months of disability payments while *You* are *Gainfully Employed* as follows:

1. We will add together the *Monthly Benefit* and *Disability Earnings* and compare to pre-disability *Monthly Earnings*.
2. If the total amount in Item 1 exceeds 100% of pre-disability *Monthly Earnings*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* reduced by the amount of the excess.
3. If the total amount in Item 1 does not exceed 100% of pre-disability *Monthly Earnings*, the Work Incentive Benefit will be equal to the *Net LTD Monthly Benefit* amount.

After the first 24 months of disability payments while *You* are *Disabled* and *Gainfully Employed*, the Work Incentive Benefit will be equal to the *Net Monthly Benefit* multiplied by the *Adjusted Loss of Salary Ratio.*

The Work Incentive Benefit will cease on the earliest of the following:

1. the date *You* are no longer *Disabled;* or
2. the end of the *Maximum Period Payable.*

Adjusted Loss of Salary Ratio is equal to: A divided by B

A= *Your pre-disability Monthly Earnings* minus *Your Disability Earnings*

B= *Your pre-disability Monthly Earnings*

Rehabilitation Incentive Income

Rehabilitation Incentive Income will be payable after the end of the *Elimination Period,* or after a period during which *You* received *LTD Monthly Benefits*. This benefit is payable if *You* are *Disabled* and *Gainfully Employed* in an occupation that has been approved as part of a *Rehabilitation Plan*.

Rehabilitation Incentive Income will be calculated during the first 12 months of *Gainful Employment* as follows:

1. If *Disability Earnings* exceed 100% of pre-disability *Monthly Earnings*, Rehabilitation Incentive Income will be equal to the *Net LTD Monthly Benefit* reduced by the amount of the excess.
2. If *Disability Earnings* do not exceed 100% of pre-disability *Monthly Earnings*, Rehabilitation Incentive Income will be equal to the *Net LTD Monthly Benefit*.

After the first 12 months of *Gainful Employment*, Rehabilitation Incentive Income will be equal to the *Net LTD Monthly Benefit* multiplied by the *Adjusted Loss of Salary Ratio.*

Rehabilitation Incentive Income will cease on the earliest of the following:

1. as stated in the *Rehabilitation Plan;*
2. the date *You* fail to comply with the requirements of the *Rehabilitation Plan;*
3. the date *You* are no longer *Gainfully Employed;* or
4. the end of the *Maximum Period Payable*.

Adjusted Loss of Salary Ratio is equal to: A divided by B

A= *Your* pre-disability *Monthly Earnings* minus *Your Disability Earnings*

B= *Your* pre-disability *Monthly Earnings*

00024-A

What is the minimum Net LTD Monthly Benefit payable under the Policy?

In no event will the *Monthly Benefit* payable for *Disability* be reduced to less than:

Tier I - $100 while *Your Monthly Benefit* is reduced by any disability benefits paid under any sick leave or salary continuation plan provide by or through *Your* Employer; or

Tier II - $100 or 10% of *Your Monthly Benefit*, prior to any reductions, whichever is greater, after any disability benefits paid under any sick leave or salary continuation plan have been exhausted.

The minimum *Net LTD Monthly Benefit* does not apply if *You* are *Gainfully Employed*.
00025 UTS

What happens if Your Deductible Sources of Income increase?

The *Net LTD Monthly Benefit* will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which *You* or *Your* dependents are eligible under any Deductible Source of Income shown above.
00026

How long will You receive benefits under the Policy?

We will send *You* a payment for each month of *Disability* up to the *Maximum Period Payable* as shown in the *Schedule of Benefits.* Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.
00027

What happens if Your Disability recurs?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than 6 months after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

Disability which recurs more than 6 months after the end of a prior *Disability* is subject to:

1. a new *Elimination Period*;
2. a new *Maximum Period Payable*; and
3. the other provisions of the Policy that are in effect on the date the *Disability* recurs.

Disability must recur while *Your* coverage is in force under the Policy.
00028

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

The Policy does not cover any loss or *Disability* caused by, resulting from, arising out of or substantially contributed, directly or indirectly, to by any one or more of the following:

- *a Pre-Existing Condition*;
- commission of, participation in, or an attempt to commit an assault or felony;
- Intentionally self-inflicted injuries;
- attempted suicide, regardless of mental capacity;
- participation in a war, declared or undeclared, or any act of war;
- active *Participation in a Riot*;

The *Policy* has limitations on:

- *Mental Disorder* - *Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24-month limit.
- *Substance Abuse* – A *Substance Abuse* (drug or alcohol) related *Disability* unless *You* are participating in a *Substance Abuse* treatment program approved by the State where the treatment program is provided. The cost of the treatment program must be borne by *You* or another group plan of the *Policyholder* (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

Except as specifically stated above, in no event will *LTD Monthly Benefits* for a *Mental Disorder* or *Substance Abuse* be paid beyond the earliest of the date:

1. 24 *LTD Monthly Benefit* payments have been made; or
2. the *Maximum Period Payable* is reached; or
3. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
4. *You* are no longer following the requirements of *Your* treatment plan under the program; or
5. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

The lifetime cumulative *Maximum Period Payable* for all disabilities due to a *Mental Disorder* and *Substance Abuse* is 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

1. are not continuous; and/or
2. are not related.

Furthermore:

- Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

00029

TERMINATION OF COVERAGE

When will Your insurance terminate?

Your coverage will terminate on the earliest of the following dates:

1. the date on which the Policy is terminated;
2. the date at the end of the period for which premium has been paid if the Employer fails to pay the required premium for *You* within 31 days after the premium due date, except for an inadvertent error; or
3. the date on which the Employer's participation under the Policy is terminated; or
4. the date *You*:
    a. are no longer a member of a class eligible for this insurance,
    b. request termination of coverage under the Policy,
    c. are retired or pensioned, or
    d. cease work because of a leave of absence (see Extension of Coverage below), furlough, layoff, or temporary work stoppage due to a labor dispute, unless *We* and the *Policyholder* have agreed in writing in advance of the leave to continue insurance during such period. Orders to active military service for 2 months or less will be covered subject to continued payment of premium.

Termination will not affect a covered loss which began while the coverage was in force.
00030 UTS

Extension of Coverage

Subject to payment of the required premium when due, *Your* coverage under the Policy will be extended until the end of the period shown for each of the following reasons:

1. leave of absence, agreed to in writing by *Your* Employer: 24 months
2. sabbatical leave, agreed to in writing by *Your* Employer: 24 months

00101 UTS

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the Policyholder approves a leave under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *You*r insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the required premium according to the terms of the Policy; and
2. coverage will terminate if *You* do not return to work as scheduled according to the terms of *You*r agreement with the *Policyholder*.

00031

Will coverage be continued if You are eligible for leave under USERRA?

If *You* are on a leave of absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and applicable state law, *Your* coverage may be continued until the end of the later of:

1. the length of time the coverage may be continued under the Certificate for an FMLA or State FML leave of absence; or

2. the length of time the coverage may be continued under the Certificate of Coverage for a leave of absence other than an FMLA or State FML leave of absence.

00032

Will coverage be continued for other leaves of absence?

If the *Policyholder* has approved more than one type of leave of absence for *You* during any one period that *You* are not Actively at Work *We* will consider such leaves to be concurrent for the purpose of determining how long *Your* coverage may continue under the Policy.

If *Your* coverage is not continued during an FMLA or State FML leave of absence, and *You* become Actively at Work immediately following the end of *Your* FMLA or State FML leave of absence, *Your* coverage will be reinstated. *We* will not apply a new *Waiting Period*, require *Evidence Of Insurability*, or apply a new *Pre-existing Condition* limitation.

If *Your* coverage is not continued during a leave of absence for active military service, and *You* return to active employment, *Your* coverage may be reinstated in accordance with USERRA and applicable state law.

In no event will *Your* coverage under the policy be continued beyond the date *Your* coverage would otherwise end according to the terms of the *When will Your insurance terminate?* provision.

00033 UTS

SUPPLEMENTAL BENEFITS AND SERVICES

DAY CARE EXPENSE BENEFIT

Are Day Care Expense Benefits available while You are Disabled?

While *Disabled* and receiving Rehabilitation Incentive Income, *You* will be reimbursed for *Day Care Expenses* for each *Eligible Child*. *You* must supply satisfactory proof to *Us* that *You* incurred such charges.

Day Care Expenses mean monthly expenses, up to $350 per child per month, to a maximum total benefit of $1,000 per month charged by a licensed day care provider who is not a member of *Your* immediate family or living in *Your* residence.

Eligible Child means *Your Dependent Child* under age 13 who lives with *You.*

***Dependent Child*(*ren*)** means any unmarried child of *Yours*, whether natural, step, foster, adopted, or other child who is in a parent-child relationship with the Employee, who is primarily dependent on *You* for financial support and maintenance.

The Day Care Expense Benefit payments will end the earliest of the following to occur:

1. the date *You* are no longer incurring *Day Care Expenses* for *Your Eligible Child*;
2. the date *You* are no longer receiving Rehabilitation Incentive Income;
3. after 12 monthly Day Care Expense Benefit payments have been made for each *Eligible Child*.

00034

EDUCATION BENEFIT

What is the Education Benefit?

If *You* continue to be *Disabled* after 6 months of receiving the *LTD Monthly Benefit* under the Policy, and *You* are not *Gainfully Employed*, We will also pay a monthly Education Benefit for each of *Your Dependent Child(ren)* who is an *Eligible Student* as defined below.

Dependent Child*(*ren) means any unmarried child of *Yours*, whether natural, step, foster or adopted, or other child who is in a parent-child relationship with the Employee, who is primarily dependent on *You* for financial support and maintenance.

An ***Eligible Student*** means the child(ren) is (are):

1. *Your Dependent Child(ren)*, and is(are) less than 23 years of age; and
2. attending a *School* for *Higher Learning* on a full-time basis.

School for Higher Learning means an institution which

1. is legally authorized by the State in which it is located; and
2. provides either a program for:
    a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
    b. gainful employment as long as such program is at least one year of training; and
3. is accredited by an Agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time

The Education Benefit is $300 per month, paid in addition to *Your LTD Monthly Benefit*. It is payable to *You*, and will not be reduced by Deductible Sources of Income. The Education Benefit will be paid to *You* upon *Our* receipt of satisfactory proof that the above requirements have been met.

The Education Benefit will be payable between school semesters or terms, if the *Eligible Student* is enrolled or registered for the next scheduled semester or term.

The Education Benefit payments will end the earliest of the following to occur:

1. the date *You* are no longer *Disabled*,
2. the date *Your Dependent Child(ren)* is (are) no longer an *Eligible Student* as defined above, or
3. the date *You* die.

00035

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

We will pay a Survivor Income Benefit to an *Eligible Survivor* when proof is received that *You* died:

1. After the Disability had continued for 12 or more consecutive months; and
2. While receiving an *LTD Monthly Benefit*

The Survivor Income Benefit shall be payable on a lump sum basis immediately after *We* receive written proof of *Your* death. The benefit will be equal to 6 times *Your Last Monthly Benefit*. The benefit shall accrue from *Your* date of death.

Eligible Survivor means *Your* Spouse, if living, or if *Your Spouse* dies before the final monthly benefit is paid, then *Your* children who are under age 23.

If payment becomes due to *Your* children, payment will be made to:

1. the children; or
2. a person named by *Us* to receive payments on the children's behalf. This payment will be valid and effective against all claims by others representing or claiming to represent the children.

Last Monthly Benefit means the *Monthly Benefit* paid to *You* immediately prior to *Your* death.

If there is no *Eligible Survivor*, *We* will pay the Survivor Income Benefit to your estate.
00036

REHABILITATION BENEFIT

What is the Rehabilitation Benefit?

If *You* are receiving a *Monthly Benefit* and *You* are participating in a *Rehabilitation Plan* approved by *Us*, *You* will receive a monthly *Rehabilitation Benefit*. The *Rehabilitation Benefit* pays 5% of *Your Gross LTD Monthly Benefit* to a maximum of $1,000 per month, subject to the maximum *Monthly Benefit* as shown in the *Schedule of Benefits*.

Eligibility for a *Rehabilitation Plan* is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for a *Rehabilitation Plan*:

1. *Your Disability* must prevent *You* from performing *Your Regular Occupation*:
2. *You* must have the physical and/or mental capacities necessary for successful completion of a *Rehabilitation Plan*; and
3. there must be a reasonable expectation that the *Rehabilitation Plan* will help *You* return to *Gainful Employment*.

The Rehabilitation Benefit is not subject to policy provisions which would otherwise increase or reduce the *Monthly Benefit.*

Rehabilitation Benefit payments will end on the earliest of the following dates:

1. after 12 monthly Rehabilitation Benefit payments have been made;
2. on the date *We* determine that *You* are no longer eligible to participate in a *Rehabilitation Plan*;
3. on the date *You* are no longer participating in the *Rehabilitation Plan*; or
4. on any other date monthly payments would cease in accordance with the Policy.

00039

ACCIDENTAL DISMEMBERMENT BENEFIT

What is the Accidental Dismemberment Benefit?

If, while insured under the Policy, *You* suffer an Injury in an *Accident*, *We* will pay an Accidental Dismemberment Benefit for the Specific Losses listed below. The Accidental Dismemberment Benefit is equal to the *Net LTD Monthly Benefit* and is payable for the length of time stated below, or until *Your* date of death, whichever first occurs. This benefit is paid in lieu of the LTD Monthly Benefit or the Work Incentive Benefit. The loss must:

1. Occur within 365 days of the *Accident*; and
2. Be the direct and sole result of the *Accident*; and
3. Be independent of all other causes.

Specific Loss	**Months Payable**
Quadriplegia	60 months
Paraplegia	55 months
Hemiplegia	50 months
Loss of both hands	46 months
Loss of both feet	46 months
Loss of the entire sight of both eyes	46 months
Loss of one hand and one foot	46 months
Loss of one hand and the entire sight of one eye	46 months
Loss of one foot and the entire sight of one eye	46 months
Loss of one hand	23 months
Loss of one foot	23 months
Loss of the entire sight of one eye	15 months
Loss of the thumb and index finger of either hand	12 months

After payment of the Accidental Dismemberment Benefit, benefits may continue subject to the other provisions of the Policy. If more than one loss results from any one *Injury*, *We* will pay only for that loss with the greatest number of months payable.

Specific Loss means, with respect to hand or foot, the actual, complete and permanent severance through or above the wrist or ankle joint; with respect to eye, the irrecoverable loss of the entire sight thereof; and with respect to thumb and index finger, the actual, complete and permanent severance through or above the metacarpophalangeal joints.

Quadriplegia means complete paralysis of both arms and both legs as a result of an *Injury* to the Spinal Cord. The paralysis must be determined by a *Doctor* to be permanent, complete and irreversible.

Paraplegia means complete paralysis of either both arms or both legs as a result of an *Injury* to the Spinal Cord. The paralysis must be determined by a *Doctor* to be permanent, complete and irreversible.

Hemiplegia means the complete paralysis of one arm and one leg on the same side of the body as a result of an *Injury* to the Spinal Cord. The paralysis must be determined by a *Doctor* to be permanent, complete and irreversible.

We may require proof of total paralysis on a periodic basis.
00041

CATASTROPHIC DISABILITY BENEFIT

What is a Catastrophic Disability Benefit?

We will pay a monthly Catastrophic Disability Benefit to *You* if *You* are receiving *LTD Monthly Benefits* (or Accidental Dismemberment Benefits) and *We* receive proof that *You* are *Catastrophically Disabled*. Catastrophic Disability Benefit payments will begin at the end of the Catastrophic Disability *Elimination Period* shown in the *Schedule of Benefits*.

You are *Catastrophically Disabled* when *We* determine that, due to *Sickness* or *Injury*:

1. *You* are unable to perform, without human assistance or regular supervision from another person, at least 2 of the 6 *Activities of Daily Living*; or
2. *You* become *Cognitively Impaired*; and
3. *You* are not *Gainfully Employed*.

When will Your coverage become effective?

You will become insured for Catastrophic Disability Benefit coverage on *Your* effective date under the *LTD* plan.

However, the Catastrophic Disability Benefit coverage will be delayed if, on *Your* effective date, *You* cannot safely and completely perform one or more of the *Activities of Daily Living* without another person's assistance, or verbal cueing, or *You* are *Cognitively Impaired*. Coverage will begin on the date *You* can safely and completely perform all of the *Activities of Daily Living* without another person's assistance or verbal cueing, or no longer are *Cognitively Impaired*.

There is no conversion privilege for the Catastrophic Disability benefit.

How much will We pay if You are Disabled?

The Catastrophic Disability Benefit is 10% of pre-disability *Monthly Earnings* to a maximum Catastrophic Disability Benefit of the lesser of the maximum *LTD Monthly Benefit* or $5,000.00.

This benefit is not subject to Policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

When will Your Catastrophic Disability Benefit payments end?

Catastrophic Disability Benefit payments will end on the earliest of the following dates:

1. the date *You* are no longer *Catastrophically Disabled*;
2. the date *You* become ineligible for *LTD Monthly Benefit* payments;
3. the end of the Catastrophic Disability Maximum Period Payable shown in the *Schedule of Benefits; or*
4. the date You die.

What claim information is needed for Catastrophic Disability Benefits?

The Filing a Claim section under the Policy applies to Catastrophic Disability Benefit coverage. *We* may also require an interview with *You.*

CAREGIVER RESPITE BENEFIT

We will pay *You* a Caregiver Respite Benefit for each day of a *Respite Interval*, subject to the conditions below:

1. *You* must be receiving a Catastrophic Disability Benefit;
2. The benefit is payable if *Informal Home Care* has been provided for at least 6 continuous months for *You* beginning with *Your Date of Disability*;

3. The benefit is payable for *Companion Care* received by *You* in *Your* home or a private residence during a *Respite Interval*;
4. The benefit is equal to the daily *Companion Care* cost incurred, not to exceed $100 per day; and
5. The benefit is payable to *You* following submission of proof of *Your* incurred costs for *Companion Care* during the *Respite Interval*.

Companion Care means medically necessary custodial care furnished during a *Respite Interval* for a minimum of 8 hours per day by a Home Health Care Provider accredited by either the Joint Commission on Accreditation of Health Care Organizations or Community Health Accreditation Program.

Informal Caregiver means the person who has primary responsibility of providing *Informal Home Care* for *You*. A person who is paid for caring for *You* cannot be an *Informal Caregiver*.

Informal Home Care means medically necessary custodial care provided at *Your* home or a private residence by an *Informal Caregiver*. Such care is provided in lieu of confinement in a nursing home, or care received at *Your* home from a paid provider.

Respite Interval means a period of one or more consecutive days during which the *Informal Caregiver* is temporarily relieved of the *Informal Home Care* duties. Two *Respite Intervals* are permitted per calendar year, subject to a cumulative total of 14 days per calendar year. Unused days expire on December 31 and cannot be carried over into any future calendar year.

CAREGIVER TRAINING BENEFIT

We will pay *You* a Caregiver Training Benefit if an *Informal Caregiver* incurs an expense to be trained to provide *Informal Home Care* for *You*, subject to the conditions below:

1. *You* must be receiving a Catastrophic Disability Benefit;
2. *Caregiver Training* must be provided by a Home Health Care Provider accredited by either the Joint Commission on Accreditation of Health Care Organizations or Community Health Accreditation Program, by a Nursing Home or by a *Hospital* while *You* are receiving the Catastrophic Disability Benefit. If *You* are in a Nursing Home or in a *Hospital*, the Caregiver Training Benefit will only be payable if the training will make it possible for *You* to return to *Your* residence where *You* can be cared for by the *Informal Caregiver*;
3. The amount of the benefit is the cost incurred for the *Caregiver Training*, subject to $500 maximum per period of *Disability*;
4. The benefit is payable to *You* following submission to *Us* of proof of *Your* costs incurred for *Caregiver Training*.

Caregiver Training means training received by the *Informal Caregiver* to care for *You* in *Your* residence.

Informal Caregiver means the person who has primary responsibility of providing *Informal Home Care* for *You* . A person who is paid for caring for *You* cannot be an *Informal Caregiver*.

Informal Home Care means medically necessary custodial care provided at *Your* home or a private residence by an *Informal Caregiver*. Such care is provided in lieu of confinement in a nursing home, or care received at *Your* home from a paid provider.

EMERGENCY ALERT SYSTEM BENEFIT

We will pay *You* an Emergency Alert System Benefit for the cost to rent or lease an *Emergency Alert System* which will allow *You* to remain in *Your* residence alone, subject to the conditions below:

1. *You* must be receiving a Catastrophic Disability Benefit;
2. The benefit is payable for a medically necessary *Emergency Alert System*;
3. *Your* condition must be such that *You* could not be left alone were it not for the presence of the *Emergency Alert System*;

4. The benefit is the lesser of $25 per month or the actual cost to rent or lease the *Emergency Alert System*;
5. The benefit is payable to *You*, in arrears, after every 6 months, following submission of proof of *Your* incurred costs for the *Emergency Alert System*; and
6. *We* will not pay for any charges incurred as a result of installing, servicing or maintaining the *Emergency Alert System.* This includes, but is not limited to, any charges for normal telephone service while the system is installed or for a home security system.

Emergency Alert System means a communication system located in *Your* residence, that is used to summon medical attention in case of a medical emergency.
00042

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

We will assist *You* and the *Policyholder* in identifying modifications *We* agree are likely to help *You* remain at work or return to work. This agreement will be in writing and must be signed by *You*, the *Policyholder* and *Us*.

When this occurs, *We* will reimburse the *Policyholder* for the cost of the modification, up to the greater of:

1. $1,500.00; or
2. 2 times *Your Last Monthly Benefit*.

We will reimburse the *Policyholder* upon completion of the following:

1. agreed upon modifications made on *Your* behalf are completed;
2. written proof of expenses incurred by *Your Policyholder* have been provided to *Us*; and
3. *You* have returned to work and are an *Actively at Work Employee.*

Last Monthly Benefit means the monthly benefit paid to *You* immediately prior to *Your* request for benefits under the Worksite Modification Benefit provision, but not including any reductions for *Deductible Sources of Income*.
00044

CONVERSION PRIVILEGE

What are Your conversion options if You end employment?

If *You* end employment with the *Policyholder*, *Your* coverage under the Policy will end. *You* may be eligible to purchase insurance under the group conversion policy. To be eligible, *You* must have been insured for at least 12 consecutive months under the *Policyholder's* group plan on the date *You* end employment. *We* will consider the amount of time *You* were insured under this Plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy, and pay the first (annual/semi-annual) premium within 31 days after the date *Your* employment ends.

The conversion policy will be at the premium rate and on the form then being made available by *Us* for conversion.

You are not eligible to apply for coverage under the group conversion policy if:

1. *You* are or become insured under another group long-term disability plan within 31 days after *Your* employment ends;
2. *You* are Disabled under the terms of the Policy;
3. *You* recover from a *Disability* and do not return to work or with the *Policyholder*;
4. *You* are on a leave of absence; or

5. *Your* coverage under the Policy ends for any of the following reasons:
    a. The Policy is canceled;
    b. The Policy is changed to exclude the class of employees to which *You* belong;
    c. *You* are no longer in an eligible class;
    d. *You* end *Your* working career or retire and receive payment form the *Policyholder's Retirement Plan*; or
    e. *You* fail to pay the required premium under the Policy.

00046

CLAIM SERVICES

What other services are available to You while You are Disabled?

If *You* are *Disabled* and eligible to receive *Disability* benefits under the Policy, *We* will evaluate *You* for eligibility to receive any of the following. *We* will make the final determination for any of the following benefits or services.

Vocational Rehabilitation Service

Rehabilitation services are available when *We* determine that these services are reasonably required to assist in returning *You* to *Gainful Employment*. Vocational rehabilitation services might include but are not limited to one or more of the following:

1. job modification;
2. job retraining;
3. job placement;
4. other activities.

Eligibility for vocational rehabilitation services is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for rehabilitation services:

1. *Your* Disability must prevent *You* from performing *Your Regular Occupation*;
2. *You* must have the physical and/or mental capacities necessary for successful completion of a rehabilitation program, and
3. there must be a reasonable expectation that rehabilitation services will help *You* return to *Gainful Employment*.

Social Security Disability Assistance

When necessary, *We* will provide an advocate for *You* in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.

00047

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The *Policyholder* can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Written Proof of Loss

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the *Policyholder* and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the *Proof of Disability* provision.

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 91 days after the end of *Your Elimination Period*. The length of the *Elimination Period* is shown in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 91 days, the claim is not affected if the proof is given as soon as possible. However, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. However, *You* can request that benefits be paid for late claims if *You* can show that:

1. It was not reasonably possible to give written proof during the 1 year period, and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *You*r proof of loss. Failure to provide complete proof of loss may delay, suspend or terminate Your benefits.

1. The date *Your Disability* began;
2. The cause of *Your Disability*;
3. The prognosis of *Your Disability*;
4. Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5. Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6. The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7. Appropriate documentation of *Your Monthly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8. If *You* were contributing to the premium cost, the *Policyholder* must supply proof of *Your* appropriate payroll deductions.
9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be made as often as reasonably necessary, but not more frequently than once every 3 months. If required, this will be at Your expense and must be received within 45 days of *Our* request. Failure to comply with such a request may delay, suspend or terminate *Your* benefits.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may result in denial, suspension or termination of benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information in support of *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2. *You* will be required to supply proof that *You* have applied for other Deductible Sources of Income such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Sources of Income. *You* must tell *Us* the nature of the Deductible Source of Income, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

00048TX

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit on a monthly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid, at *Our* option, to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; or 4) *Your* estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.

00049

Can You assign Your benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs. The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.

We have the right to recover from *You* any amount that is an overpayment of benefits under the Policy. *You* must refund to us the overpaid amount. *We* may also, without forfeiting our right to collect an overpayment through any means legally available to *Us*, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the *Minimum Monthly Benefit*.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery. If *LTD Monthly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *LTD Monthly Benefits* payable under the Policy.

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*. *We* will bear any expenses associated with *Our* pursuit of subrogation or recovery.

00050

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the *Policyholder's* application, the *Employee's* certificate of coverage, and *You*r application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the *Policyholder* and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the *Policyholder* in applying for the Policy will make it void unless the representation is contained in the signed application; or

2. any *Employee* in applying for insurance under the Policy will be used in defense to a claim under the Policy unless it is contained in a written application signed by the Insured and a copy of such application is or has been given to him or to his personal representative.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against *U*s:

1. until 60 days after proof of claim has been given; or

2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

Clerical error or omission by *Us* to the *Policyholder* will not:

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the Policy; or

2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:

1. Use the facts to decide whether *You* have coverage under the Policy and in what amounts; and

2. Make a fair adjustment of the premium.

Misstatement of Age

If *Your* age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon *Your* age, as shown in the Benefit Duration Schedule, the amount of the benefit will be the amount *You* would have been entitled to if *Your* correct age were known.

Note: A refund of premium will not be made for a period more than twelve months before the date the Company is advised of the error.

Incontestability

The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the Policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the Policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Conformity with State Statutes and Regulations

If any provision of the Policy conflicts with the statutes and regulations of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.

Workers' Compensation or State Disability Insurance

The Policy is not in place of, and does not affect the requirements for coverage by any workers' compensation or state disability insurance.

Agency

Neither the *Policyholder*, any employer, any associated company, nor any administrator appointed by the foregoing is *Our* agent.

General Provisions

We have the right to inspect all of the *Policyholder's* records on the Policy at any reasonable time. This right will extend until:

1. 2 years after termination of the Policy; or

2. all claims under the Policy have been settled,

whichever is later.

The Policy is in the *Policyholder's* possession and may be inspected by *You* at any time during normal business hours at the *Policyholder's* office.

Premium Provisions

The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Contributory* insurance coverage and to remit such premiums for the entire time coverage under the Policy is in effect.

Premium charges will begin on the premium due date which coincides with or follows the addition of coverage. Premium charges for termination of coverage will end on the premium due date which coincides with or next follows the termination. If your *Monthly Earnings* increase during the plan year (any time other than September 1), the premium adjustment will take effect on the following September 1.

This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.
00051TX UTS

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.
00052

Actively at Work or ***Active Work*** means that *You* must be:

1. working for the *Policyholder* on an active basis; or
2. working at least the minimum number of hours shown in the Schedule of Benefits: and either:
   a. working at the *Policyholder*'s usual place of business; or
   b. working at a location to which the *Policyholder*'s business requires *You* to travel;
3. are paid regular earnings by the *Policyholder*, and
4. not a temporary or seasonal *Employee*.

If the institutions are not in session, *Actively at Work* means *You* would be working for the *Policyholder* for earnings that are paid regularly and *You* would be able to perform the *Material and Substantial Duties* of *Your Regular Occupation*.

You will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave).

00053

Activities of Daily Living means:

1. Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
2. Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
3. Transferring – Moving into or out of a bed, chair or wheelchair.
4. Bathing – Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
5. Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
6. Continence – Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

00054

Annual Enrollment Period means a period of time during which eligible Employees may apply for Voluntary STD coverage or request changes to their STD benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.
00055

Cognitively Impaired means you suffer severe deterioration, or loss of:

1. memory;
2. orientation; or
3. the ability to understand or reason,

so that you are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.
00056

Date of Disability is the date *We* determine that *You* are *Disabled*.
00057

Disability or ***Disabled*** means that *You* satisfy the definition of either Total Disability or Partial Disability.
00058

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

If *Your Disability Earnings* routinely fluctuate widely from month to month, *We* may average *Your Disability Earnings* over the most recent three months to determine if *Your* claim should continue. If *We* average *Your Disability Earnings*, *We* will not terminate *Your* claim unless the average of *Your Disability Earnings* from the last three months exceeds 80% of *Your Indexed Monthly Earnings.*
00059

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your* immediate family. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.
00061

Elimination Period means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.
00062

Employee means an *Actively at Work Employee* whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, who is *Actively at Work* for at least the number of hours per week as stated in the Application and is reported on the *Policyholder's* records for Social Security and withholding tax purposes.
00069

Employer means the *Policyholder* and includes any division, subsidiary, or affiliated company named in the Policy.
00097 UTS

Gainful Occupation, Gainful Employment or ***Gainfully Employed*** means the performance of any occupation for wages, remuneration or profit, for which You are qualified by education, training or experience on a full-time or part-time basis.
00063

Generally Accepted Medical Practice or ***Generally Accepted in the Practice of Medicine*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
00064

Gross LTD Monthly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
00065

Hospital or Health Care Facility is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
00066

Indexed Monthly Earnings means *Your Monthly Earnings* adjusted on each anniversary of benefit payment by the lesser of 10% or the current annual percentage increase in the *Consumer Price Index*. *Your Indexed Monthly Earnings* may increase or remain the same, but will never decrease.

Consumer Price Index (CPI-W) means the Consumer Price Index for all urban wage earners and clerical workers in the United States as published by the Bureau of Labor Statistics of the United States Department of Labor or its successors. If the CPI-W is discontinued or changed, *We* may use another index that most closely reflects the cost of living in the United States.

Indexing is only used as a factor in the determination of the percentage of lost earnings while *You* are *Disabled* and working in a *Gainful Occupation*.
00067

Injury means bodily injury that is the direct result of an *Accident* and not related to any other cause. The *Injury* must occur, and *Disability* resulting from the *Injury* must begin while *You* are covered under the *Policy*. *Injury* that occurs before *You* are covered under the Policy will be treated as a *Sickness*.
00068

LTD means Long-Term Disability.
00070

Male pronoun, whenever used, includes the female.
00071

Material and Substantial Duties means duties that:

1. are normally required for the performance of *Your Regular Occupation*; and
2. cannot be reasonably omitted or modified, except that if *You* are required to work on average in excess of 40 hours per week, *We* will consider *You* able to perform that requirement if *You* have the capacity to work 40 hours.

00072

Maximum Capacity means, based on *Your* restrictions and limitations:

1. During the first 24 Month consecutive months of *monthly payments*, the greatest extent of work *You* are able to do in *Your Regular Occupation*; and
2. Beyond 24 Month consecutive months of *monthly payments*, the greatest extent of work *You* are able to do in any *Gainful Occupation*.

00073

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
00074

Maximum Period Payable, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.
00075

Mental Disorder means a disorder found in the current diagnostic standards of the American Psychiatric Association.
00076

Monthly Benefit means the LTD Monthly Benefit shown in the *Schedule of Benefits* which applies to *You*.
00077

Monthly Earnings will equal the greater of:
1. 1/12th of *Your* last reported gross annual income from *Your Employer* in effect on the day immediately prior to *Your Date of Disability*; or
2. 1/12th of *Your* gross annual income from *Your Employer* in effect on September 1 immediately prior to *Your Date of Disability.*

It includes:
1. hazardous duty pay;
2. longevity pay;
3. *Employee* contributions made through a salary reduction agreement with *Your* Employer to an IRC Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified *Employee* Retirement Plan or deferred compensation arrangement; and
4. amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRC Section 125 plan.

It does not include:
1. commissions;
2. bonuses;
3. overtime pay;
4. *Your* Employer's contribution on *Your* behalf to a Retirement Plan or deferred compensation arrangement; or
5. any other extra compensation.

00078 UTS

Net LTD Monthly Benefit means the *Gross LTD Monthly Benefit* less the Deductible Sources of Income.
00079

Participation *in a Riot* shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.
00080

Policyholder means the person, firm or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy.
00096 *UTS*

Pre-existing Condition means a condition which;

1. was caused by, or results from a *Sickness* or *Injury* for which *You* received medical treatment, or advice was rendered, prescribed or recommended whether or not the Sickness was diagnosed at all or was misdiagnosed within 3 months prior to *Your* effective date; and
2. results in a *Disability* which begins in the first 12 months after *Your* effective date.

00081

Regular Occupation means the occupation that *You* are routinely performing when *Your Disability* begins. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location.
00082

Retirement Plan means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
00084

Riot shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.
00085

Schedule of Benefits means the schedule which is a part of this certificate.
00086

Sickness means sickness or disease causing *Disability* which begins while *You* are covered under the Policy.
00087

Spouse means lawful spouse in the jurisdiction in which *You* reside.
00091

Substance Abuse means a pattern of pathological use of alcohol or other psychoactive drugs resulting in: impairment of social and or occupational functioning, debilitating physical condition, inability to abstain from or reduce consumption of the substance, or the need for daily substance use for adequate functioning.
00092

Waiting Period as shown in the Schedule of benefit means the continuous length of time immediately before *Your* Effective Date during which *You* must be in an Eligible Class. Any period of time prior to the Policy Effective Date *You* were Actively at Work for *Your* Employer will count towards completion of the Waiting Period.
00093

We, ***Our*** and ***Us*** mean the Dearborn Life Insurance Company, Chicago, Illinois.
00094

You, ***Your*** and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
00095

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Dearborn Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Regulatory Inquiry Representative at 1-630-691-0365
Toll-free: 1-877-442-4207
Email: DOIComplaintsTX@bcbstx.com
Mail: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call: 1-800-252-3439
Online: www.tdi.texas.gov
Email:
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Dearborn Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Regulatory Inquiry Representative at 1-630-691-0365
Teléfono gratuito: 1-877-442-4207
Correo electrónico: DOIComplaintsTX@bcbstx.com
Dirección postal: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

Individual annuities: Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. There may be other exceptions that aren't included in this notice. When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits

   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

   If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

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

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The benefits described in your certificate are insured by a Disability Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Texas (“We” or "Insurer"), pursuant to an "employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1), established by your employer, or where applicable, employee organization (the “Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to you pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE :

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department

Blue Cross and Blue Shield of Texas

701 E. 22nd Street

Lombard, IL. 60148

1-877-442-4207

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Disability Insurance Plans

We will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, We notify you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If the extension is due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which We send you notice of the extension until the date We receive your response to our request. This period will be no longer than 45 days after We have requested the information. At that time We will decide your claim based on the information We have at that time.

If the claim is denied, in whole or in part, We will provide You with a written notice giving the following:

- the reason for the denial;
- the reasons for the adverse benefit determination;
- reference to the specific Policy provisions on which the determination is based;
- a description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied on in making the adverse determination or, alternatively, a statement that such rules, guideline, protocols, standards or other similar criteria of the Plan do not exist;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- a description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of Your rights to bring a civil action under ERISA §502(a), 29 U.S.C. §1132(a) following an adverse benefit determination on review.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a. request a review upon written application within 180 days of the claim denial;

b. request, free of charge, copies of all documents, records and other information relevant to your claim; and

c. submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after We receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, We notify you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date We receive your response to the request.

If the adverse benefit determination is upheld on administrative appeal, in whole or in part, We will provide You with a written notice giving the following:

- the reasons for the adverse benefit determination;
- reference to the specific Policy provisions on which the determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied on in making the adverse determination or, alternatively, a statement that such rules, guideline, protocols, standards or other similar criteria of the Plan do not exist;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim; and
- a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of Your rights to bring a civil action under ERISA §502(a), 29 U.S.C. §1132(a) following an adverse benefit determination on review.

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148