BlueCross BlueShield of Texas

# Term Life and AD&D Insurance

## Employee Benefit Booklet

**Uplift Education**

**VF028267-0001**

**Class 1-01**



**06/24/2023**

# Dearborn Life Insurance Company

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

(A stock life insurance company, herein called “We” “Us” or “Our”)

**Having issued Group Policy No. VF028267-0001**

(herein called the *Policy*)

**to**

**Uplift Education**

(herein called the *Policyholder*)

## Group Insurance Certificate

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*, and it takes effect as 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 Group Insurance Certificate (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

**Death Benefits will be reduced if an accelerated death benefit is paid.**

**DISCLOSURE:** The Accelerated Death Benefit offered under this Policy is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the Accelerated Death Benefit qualifies for such favorable tax treatment, the benefits will be excluded from the insured Employee’s income and not subject to federal taxation. Tax laws relating to Accelerated Death Benefits are complex. The insured Employee is advised to consult with a qualified tax advisor about circumstances under which he or she could receive the Accelerated Death Benefit excludable from income under federal law.

Receipt of the Accelerated Death Benefit payment may affect the insured Employee, his or her spouse, or his or her family’s eligibility for public assistance such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. The insured Employee is advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect the insured Employee, his or her spouse, or his or her family’s eligibility for public assistance.

00124 TX

**Basic & Supplemental Group Term Life Insurance Certificate with Accidental Death & Dismemberment**
**Dependent Life Insurance with Dependent Accidental Death and Dismemberment Benefits**

**Non-Participating**

# *TABLE OF CONTENTS*

# *SCHEDULE OF BENEFITS*

| | |
|---|---|
| **POLICYHOLDER:** | Uplift Education |
| **POLICY NUMBER:** | VF028267-0001 |
| **EFFECTIVE DATE:** | September 1, 2023 |
| **ANNUAL ENROLLMENT PERIOD:** | 7/1-7/31 |

| | | |
|---|---|---|
| **ELIGIBILITY: Class 01** | All active full time Employees of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible. | |
| **Eligibility Waiting Period:** | Current *Employees:* | None |
| | New *Employees:* | First of the month following Date of Hire of continuous, full-time active work |
| **Policyholder Contribution:** | Basic Life & AD&D | 100% of premium |
| | *Dependent* Life & AD&D | 0% of premium |
| | *Supplemental* Life & AD&D | 0% of premium |

**GROUP TERM LIFE INSURANCE**

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|---|---|
| ***Employee*** **Basic Life Benefit Amount** | 1.00 times *Annual Earnings* from a minimum of $10,000 to a maximum of $100,000 rounded to the next higher $1,000 |
| ***Employee Supplemental*** **Life Benefit Amount** | Incremental selection from a minimum of $10,000 to a maximum of $500,000 in increments of $10,000, not to exceed 5 times *Annual Earnings* rounded to the next higher $10,000, whichever is less |
| | ***Annual Earnings*** means *Your* gross annual income from the *Policyholder* on the July 1 immediately preceding the date of loss. It includes *Your* total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. *Annual Earnings* does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than the *Policyholder*. |
| Guarantee Issue Benefit Limit | *Employee Supplemental:* $300,000 |
| | *Spouse Supplemental*: $30,000 |
| | Amounts in excess of the Guarantee Issue Benefit Limit are subject to satisfactory *Evidence of Insurability* |

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|---|---|
| **Reduction of Benefits** | Basic Group Term Life benefits reduce by 35% at age 65 and further reduce by 50% of the original amount at age 70. Benefits terminate at retirement.<br><br>*Supplemental* Group Term Life benefits reduce by 35% at age 65 and further reduce by 50% of the original amount at age 70. Benefits terminate at retirement.<br><br>*Dependent Spouse Supplemental* Group Term Life benefits reduce by 35% at age 65 and benefits terminate at age 70. |
| **Waiver of Premium** | |
| Waiver Eligibility | Totally Disabled prior to age 60 without interruption from the last date worked for at least 6 months |
| Insured Eligibility | *Employee* |
| Maximum Waiver of Premium Duration | *Your* Social Security Normal Retirement Age |
| **Accelerated Death Benefit (ADB)** | |
| Benefit Amount | 75% Basic and *Supplemental* Term Life Insurance In force |
| Insured Eligibility | *Employee* |
| Minimum Covered Life Insurance Amount | $15,000 |
| Maximum ADB Payment | $250,000 |
| Minimum ADB Payment | $7,500 |
| **Portability** | |
| Benefit Eligibility | *Supplemental* Life |
| Insured Eligibility | *Employee, Dependent Spouse, Dependent Child* |
| Portability Benefit Duration | Age 65 |
| **DEPENDENT TERM LIFE INSURANCE** | |
| *Spouse* Benefit Amount | *Supplemental*: Incremental selection from a minimum of $5,000 to a maximum of $100,000 in increments of $5,000, not to exceed 50% of the *Employee* amount |
| *Child*(ren) Benefit Amount | *Supplemental*:<br><br>$1,000 – Age live birth to 6 months<br><br>$10,000 - age 6 months to 26 years |

**GROUP ACCIDENTAL DEATH & DISMEMBERMENT**

| | |
|---|---|
| ***Employee* Basic AD&D Coverage Amount** | 1.00 times *Annual Earnings* from a minimum of $10,000 to a maximum of $100,000 rounded to the next higher $1,000 |
| ***Employee Supplemental* AD&D Coverage Amount** | Incremental selection from a minimum of $10,000 to a maximum of $500,000 in increments of $10,000 , not to exceed 5 times Annual Earnings rounded to the next higher $10,000, whichever is less |
| | ***Annual Earnings*** means *Your* gross annual income from the *Policyholder* on the July 1 immediately preceding the date of loss. It includes *Your* total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. *Annual Earnings* does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than the *Policyholder*. |
| **Dependent AD&D Benefit Amount** | |
| *Spouse* | *Supplemental*: Incremental selection from a minimum of $5,000 to a maximum of $100,000 in increments of $5,000, not to exceed 50% of the *Employee* amount |
| **Dependent AD&D Benefit Amount** | |
| *Dependent Child*(ren) | *Supplemental*: |
| | $1,000 – Age live birth to 6 months |
| | $10,000 - age 6 months to 26 years |
| **Reduction of Benefits** | Basic Accidental Death and Dismemberment benefits reduce by 35% at age 65 and further reduce by 50% of the original amount at age 70. Benefits terminate at retirement. |
| | *Supplemental* Accidental Death and Dismemberment benefits reduce by 35% at age 65 and further reduce by 50% of the original amount at age 70. Benefits terminate at retirement. |
| | *Dependent Spouse Supplemental* Accidental Death and Dismemberment benefits reduce by 35% at age 65 and benefits terminate at age 70. |
| **Seat Belt Benefit** | 10% of *Employee* Coverage Amount, to a maximum of $25,000 |
| **Air Bag Benefit** | 5% of *Employee* Coverage Amount to a maximum of $5,000 |
| **Repatriation Benefit** | Actual costs to a maximum of $5,000 |
| **Education Benefit** | |
| Benefit Amount | 2% of *Employee* Coverage Amount, to a maximum of $2,000 per year |
| Maximum Benefit Duration | Benefit payable for a maximum of 4 Years |
| Eligible Dependents | Age live birth to age 19 years (23 if a full-time student) |
| **Day Care Benefit Amount** | |
| Benefit Amount | 2% of *Employee* Coverage Amount to a maximum of $2,000 per year |
| Maximum Benefit Duration | 4 Years |
| **Maximum Spouse Training Benefit** | $5,000 |
| **Coma Benefit Amount** | |
| Benefit Amount | 1% of *Employee* Coverage Amount to a maximum of $5,000 per month |
| Maximum Benefit Duration | 4 Months |

# *ELIGIBILITY AND EFFECTIVE DATE PROVISIONS*

***Who is eligible for this insurance?***

The eligibility for this insurance is as indicated in the *Schedule of Benefits*.

The *Eligibility Waiting Period* is set forth in the *Schedule of Benefits*.
00001

***When does Your Noncontributory insurance become effective?***

***Noncontributory*** means the *Policyholder* pays 100% of the premium for this insurance.

***Current Employees***

If *You* are an eligible *Employee* on the *Policy* effective date, *Your Noncontributory* coverage under the *Policy* will become effective on the date indicated in the *Schedule of Benefits*, provided *You* are *Actively at Work* on that day.

***New Employees***

If *You* become an eligible *Employee* after the *Policy* effective date, *Your Noncontributory* coverage under the *Policy* will become effective on the date indicated in the *Schedule of Benefits*, provided *You* are *Actively at Work* on that day.

If *You* waive all or a portion of *Your Noncontributory* coverage and choose to enroll at a later date, *You* are considered a late applicant and must furnish *Evidence of Insurability* satisfactory to *Us* before coverage can become effective. Coverage will become effective on the date *We* determine that the *Evidence of Insurability* is satisfactory and *We* provide written notice of approval.

*You* must be *Actively at Work* for coverage under the *Policy* to become effective.
00003

***When does Your Contributory insurance become effective?***

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

*You* may apply for *Supplemental* insurance coverage during the *Annual Enrollment Period* as indicated in the *Schedule of Benefits*. *Your* coverage will become effective as follows, provided *You* are *Actively at Work* on that date:

*Your Contributory* coverage for amounts up to the Guarantee Issue Benefit Limit will become effective on the latest of the following dates provided *You* are *Actively at Work* on that date:

1. If *You* enroll for coverage prior to the *Policy* effective date and *Evidence of Insurability* is not required, the *Policy* effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for *Supplemental* coverage within 31 days after *Your* eligibility date, *You* must wait until the next *Annual Enrollment Period* to apply, 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 requested within 31 days of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.

*You* must be *Actively at Work* for coverage under the *Policy* to become effective.

***Enrollment Form*** means the application *You* complete to apply for coverage under the *Policy*.
00004-B

***Change in Family Status***

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

***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.

00005

***When is Evidence of Insurability required?***

*Evidence of Insurability* is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date or *You* were eligible to enroll under the *Prior Policy* and did not enroll before the expiration of the time allowed to enroll; or
2. *You* voluntarily canceled *Your* insurance and choose to reapply; or
3. *Your* coverage amount exceeds the Guarantee Issue Benefit Limit as set forth in the *Schedule of Benefits*; or
4. *You* apply to increase *Your* coverage amount during an *Annual Enrollment* Period; or
5. An increase to *Your Annual Earnings* results in an increase to *Your* Life Insurance benefit of more than $50,000, and that amount exceeds the Guarantee Issue Benefit Limit.
6. *You* enroll for additional coverage that is greater than the next 3 higher coverage option during an *Annual Enrollment Period*.

Receipt of premium before *We* have approved *Evidence of Insurability* will not constitute acceptance and does not guarantee issuance of any benefit amount prior to *Our* approval.

***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 if *You* enroll within 31 days after *Your* eligibility date. *Evidence of Insurability* will be provided at *Your* expense if *You* are a late applicant, which means *You* enroll for insurance more than 31 days after *Your* eligibility date.

***Evidence of Insurability Form*** means a form provided or approved by *Us* on which *You* provide a statement of *Your* medical history.

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

00006-B

***What is an Annual Enrollment period?***

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

Eligible *Employees* may enroll for coverage, apply for additional coverage, or request changes to their current *Supplemental* 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 after their eligibility date. If a new *Employee* does not elect *Supplemental* coverage within that time period, he must wait for the next *Annual Enrollment* to enroll unless he qualifies 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.

00007

***If You are not Actively at Work, when does coverage become effective?***

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an *Injury*, illness or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work*.

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

1. not *Hospital Confined*; or;
2. disabled due to an *Injury* or *Sickness*.

00008

***What happens if We are replacing an existing Policy? Is continuity of coverage provided?***

If *You* were insured for coverage under the *Prior Policy* on the day immediately preceding *Our Policy's* Effective Date, and subject to the payment of premiums when due, *We* agree to provide continuity of coverage for *You* and *Your Eligible Spouse* and *Eligible Dependent Children* if *You* are not *Actively at Work* on *Our Policy* Effective Date. If *Your* coverage is extended under this provision, *You* are not eligible for Portability or *Waiver of Premium* benefits under *Our Policy*.

Coverage under this provision will end on the earlier of:

1. The date *You* return to *Active Work*, at which time *You* may be covered as an *Actively at Work Insured* under *Our Policy*;
2. The last day of the 12th month following *Our Policy* Effective Date;
3. The last day *You* would have been covered under the *Prior Policy* had the *Prior Policy* not terminated;
4. The date *You* are approved for *Waiver of Premium* under the *Prior Policy*; or
5. The date insurance terminates for one of the reasons stated in the Termination Provisions of *Our Policy.*

The amount of coverage provided will be the lesser of:

1. The amount of coverage *You* had under the *Prior Policy;* or
2. The amount of coverage *You* are eligible for under *Our Policy.*

Reduced by any amount:

1. In-force, paid or payable under the *Prior Policy;* or
2. Which would have been payable if timely election had been made under the *Prior Policy*.

***Prior Policy*** means the group term life insurance policy issued to the *Policyholder* whose coverage terminated immediately prior to *Our Policy* Effective Date.

00009-C

***Changes to Your coverage***

A change in *Your* coverage may occur if:

1. There is a *Policy* change; or
2. *You* enter another class and become eligible for a change in benefits; or
3. *You* experience a qualified *Change in Family Status*
4. There is a change in *Your Annual Earnings*, which results in an increased benefit amount

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*.

Additional coverage for reasons other than a Policy change will be effective as indicated in the ***"When Does Your Contributory insurance become effective?"*** section, or the later of:

1. The date *You* enroll for the additional coverage; or
2. The date *You* become eligible for the additional coverage, if enrollment is not required; or
3. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

In order for *Your* additional coverage to begin, *You* must be *Actively at Work*.

Additional *Contributory* coverage is subject to payment of premium.

Any decrease in coverage will take effect immediately.

Exception: Increases or decreases to *Your Supplemental* benefit program elected during the *Annual Enrollment Period* will become effective on the next Policy anniversary date, provided *You* are *Actively at Work* on that day.
00010

***Eligibility after You Terminate Employment***

If *Your* coverage ends due to termination of employment and *You* do not elect continued coverage under the Portability Benefit provision, *You* must meet all the requirements of a new *Employee* if *You* are rehired at a later date.

If *You* converted all or part of *Your* group life insurance when employment terminated, the individual policy must be surrendered upon return to *Active Work.*
00011

# *TERM LIFE INSURANCE BENEFIT*

***THIS BENEFIT ONLY APPLIES TO YOU IF YOU HAVE ELECTED TERM LIFE INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.***

***When is a Life Insurance Benefit payable?***

*We* will pay *Your* beneficiary the amount of life insurance in force as of the date of *Your* death provided:

1. *You* are insured under the *Policy* on the date of death, and
2. *We* receive *Proof* of death.

*We* will determine the amount of insurance payable based upon the S*chedule of Benefits*.
00012 TX

***Are Life Insurance Benefits payable for death by suicide?***

Life Insurance benefits including Waiver of Premium, increased benefit amounts elected during subsequent *Annual Enrollment periods* and Accelerated Death Benefits, will not be payable for a loss caused by suicide or attempted suicide, while sane or insane, within one (1) year from the effective date of *Your Supplemental* Term Life Insurance or the effective date of any increased amount of life insurance. *Our* liability for a death claim by suicide will be limited to the return of premium paid for this life insurance.

If *You*:

1. were covered for *Supplemental* life insurance under a prior carrier's policy; and
2. were insured under the *Policy* on its effective date;
3. and there was no lapse in coverage,

*We* will consider the time *You* were covered under the *Policy* and under the prior carrier’s policy in determining if benefits are payable for death by suicide. The death benefit, if payable under this provision, will be the lesser of the benefit under the *Policy* or the benefit under the prior carrier’s policy.
00013

***Who will receive Your Life Insurance Benefits?***

*Your* beneficiary designation must be made on a form which *We* provide or on a form accepted by *Us.* If two or more beneficiaries are named, payment of proceeds will be apportioned equally unless *You* had specified otherwise. The *Policyholder* may not be named as beneficiary. Unless *You* provide otherwise, if a beneficiary dies before *You*, *We* will divide that beneficiary's share equally between any remaining named beneficiaries.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, *We* will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent *Us* from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

***Facility of Payment***

If no named beneficiary survives *You* or if *You* do not name a beneficiary, We will pay the amount of insurance:

1. to *Your* spouse, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than $250 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death. Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.
00014 TX

***May You change Your beneficiary?***

*You* may change *Your* beneficiary at any time by completing a form provided or accepted by *Us*, and sending it to the *Policyholder*. *Your* written request for change of beneficiary will not be effective until it is recorded by the *Policyholder*. After it has been so recorded, it will take effect on the later of the date *You* signed the change request form or the date *You* specifically requested. If *You* die before the change has been recorded, *We* will not alter any payment that *We* have already made. Any prior payment shall fully discharge *Us* from further liability in that amount.

If *You* are approved for continued life coverage under the Waiver of Premium or Portability provision, *You* may be asked to name a beneficiary. A beneficiary designation made in connection with Waiver of Premium or Portability, if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*. Such change of beneficiary only applies while *You* qualify for continued coverage under the Waiver of Premium or Portability provision.

If continuation of life insurance under the Waiver of Premium or Portability provision ceases, and *You* are employed by the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.
00015

## *CONVERSION OF LIFE INSURANCE*

***How much Life Insurance may You convert if eligibility terminates?***

*You* may convert to an individual policy of life insurance if *Your* life insurance, or a portion of it, ceases because:

1. *You* are no longer employed by the *Policyholder*; or
2. *You* are no longer in a class which is eligible for life insurance.

In either of these situations, *You* may convert all or any portion of *Your* life insurance which was in force on the date *Your* life insurance ceased.

***How much Life Insurance may You convert if the policy terminates or is amended?***

*You* may also convert to an individual policy of life insurance if *Your* life insurance ceases because:

1. life insurance benefits under the *Policy* cease; or
2. the Policy is amended making *You* ineligible for life insurance; however, in either of these situations,

*You* must have been insured under the *Policy*, or the *Policy* it replaced, for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which *You* become eligible under this or any other group policy within 31 days after the date *Your* life insurance ceased; or
2. $10,000.

***How to apply for conversion***

*We* must receive written application and the first premium for the individual life insurance policy within 31 days after life insurance under the *Policy* ceased. No *Evidence of Insurability* will be required.

The individual policy will be a policy of whole life insurance. It will not contain waiver of premium, accelerated death benefit, disability benefits, accidental death and dismemberment benefits or any other ancillary benefits.

The minimum issue amount of an individual conversion policy is $2,000. The premium for the individual policy will be based on:

1. *Our* current rates based upon *Your* attained age; and
2. the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which *You* could apply for conversion.

If *You* die during a period when *You* would have been entitled to have an individual policy issued to *You* and if *You* die before such an individual policy became effective, *We* will pay *Your* beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. *Your* death occurred during the 31-day period within which *You* could have made application; and
2. *We* receive proof of death.

If life insurance benefits are paid under the *Policy*, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

If *You* have elected Portability, conversion is not available for amounts continued under Portability unless coverage under Portability terminates. Conversion from Portability will be as specified under Portability.

Notice. If the *Policyholder* fails to notify *You* at least 15 days prior to the date insurance under the *Policy* would cease, *You* shall have an additional period within which to elect conversion coverage; but nothing herein shall be construed to continue any insurance beyond the period provided for in the *Policy*. The additional election period shall expire 15 days immediately after the *Policyholder* gives *You* notice, but in no event shall it extend beyond 60 days immediately after the expiration of the 31-day period explained above.
00016 TX

## *WAIVER OF PREMIUM*

***What is the Waiver of Premium benefit?***

*We* will continue *Your* Basic and *Supplemental* life insurance benefit under the *Policy* without further payment of life insurance premium if *You* become *Totally Disabled*, provided:

1. *You* are insured under the *Policy* and were *Actively at Work* on or after the effective date of the *Policy*; and
2. *You* are under the age of 60; and
3. *You* provide *Us* with satisfactory written proof of *Total Disability* within 12 months after the date *You* became *Totally Disabled*; and
4. *Your Total Disability* has continued without interruption for at least 6 months; and
5. *You* are still *Totally Disabled* when *You* submit the proof of disability; and
6. all required premium has been paid.

***Total Disability*** or ***Totally Disabled*** means *You* are diagnosed by a *Doctor* to be completely unable because of *Sickness* or *Injury* to engage in any occupation for wage or profit or any occupation for which *You* become qualified by education, training or experience.

*We* will waive premium beginning the month after *We* receive satisfactory proof that *You* have been *Totally Disabled* for at least 6 months. Premium will continue to be waived provided *You*:

1. remain *Totally Disabled*; and
2. provide satisfactory written proof of continuing *Total Disability* upon request. *We* will not request proof of continuing Total Disability more frequently than once every three months during the first two years of Total Disability, and not more frequently than once a year after the Insured has been Totally Disabled for two years.

*You* are responsible for obtaining initial and continuing proof of *Total Disability*.

*You* will be covered for the amount of life insurance in force as of the date *Total Disability* commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as shown on the *Schedule of Benefits* or which are the result of an amendment to the *Policy*, but in no event will the insurance amount increase while *Your* life insurance is continued under Waiver of Premium. This life insurance coverage will continue without the payment of premium until *You* are no longer *Totally Disabled, or* attain the Maximum Waiver of Premium Duration as set forth in the *Schedule of Benefits* or retire, whichever occurs first.

*We* may have *You* examined at reasonable intervals during the period of claimed *Total Disability*, but not more frequently than once every three months during the first two years of *Total Disability*, and not more frequently than once a year after the *Insured* has been Totally Disabled for two years. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if *You* refuse to be examined as and when required.

If *You* are approved for continued coverage under the Waiver of Premium provision, *You* will be asked to name a beneficiary. That beneficiary designation:

1. will only apply while *Your* coverage continues under this Waiver of Premium provision; and

2. if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*.

*We* will pay the amount of life insurance in force to *Your* beneficiary if *You* die before furnishing satisfactory proof of *Total Disability*, if:

1. *You* die within one year from the date *You* became *Totally Disabled*; and
2. *We* receive proof that *You* were continuously *Totally Disabled* until the date of death; and
3. *We* receive proof of death.

If continuation of life insurance under the Waiver of Premium provision ceases while the *Policy* is still in force, and *You* are employed by the *Policyholder*, *Your* life insurance will continue provided premium payments begin on the next premium due date. If *You* return to work with the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are no longer employed by the *Policyholder*, *You* may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of this Certificate.

***How does termination of the Policy affect Your insurance under the Waiver of Premium Benefit?***

Termination of the *Policy* will not affect any insurance that has been continued under this Provision prior to the termination date.

***What if You are Totally Disabled and the Policy ends before You satisfy the Elimination Period?***

*Your* coverage under the *Policy* will end if the *Policy* ends before *You* satisfy the *Elimination Period*. However, when the *Policy* ends *You* may be entitled to convert *Your* coverage to an individual plan of life insurance as described in the Conversion of Life Insurance provision.

*You* may still submit a claim for Waiver of Premium Benefits after the *Policy* ends. However, *You* must be *Totally Disabled*, pay the Conversion premium for the full length of the Elimination Period and qualify for the Waiver of Premium Benefits.

**At no time can *You* be covered under both the individual conversion policy and this *Policy*.**

Upon receipt of timely notice and due proof of *Your Total Disability We* will evaluate *Your* claim. If *We* determine that *You* qualify and *You* pay all applicable premiums, *We* will approve *Your* Waiver of Premium claim under the *Policy* and agree to rescind any individual policy of life insurance issued to *You* under the Conversion privilege. *We* will refund any premiums paid for such coverage. Insurance under the *Policy* will not go into effect until *We* approve your claim in writing.

00017TXa

# *ACCELERATED DEATH BENEFIT*

***What is the Accelerated Death Benefit?***

The *Accelerated Death Benefit* is a percentage of *Your* group Basic and *Supplemental* term life insurance which is payable to *You* prior to *Your* death if *We* receive acceptable proof that *You* have a *Terminal Condition*. The *Accelerated Death Benefit* is limited to the maximum and minimum amounts shown on the *Schedule of Benefits*, and is payable only once to any one *Insured*.

The *Accelerated Death Benefit* is calculated on the group Basic and *Supplemental* term life insurance benefit amount in force under the *Policy* on the date *You* are diagnosed with a *Terminal Condition*. If *Your* group term life insurance will reduce, due to age, within 12 months after the date *We* receive proof, the *Accelerated Death Benefit* will be calculated on the reduced group Basic and *Supplemental* term life insurance benefit.

***Who is Eligible for an Accelerated Death Benefit?***

This benefit only applies to *Insureds* with at least the Minimum Covered Life Insurance Benefit amounts set forth in the *Schedule of Benefits*. *You* must have been *Actively at Work* on or after the effective date of the *Policy* to be eligible for an *Accelerated Death Benefit*.

This benefit does not apply to Accidental Death and Dismemberment benefits.

***Terminal Condition*** means *You* have been examined and diagnosed by *Your Doctor* as having a non-correctable health condition that, with reasonable medical certainty, will result in *Your* death within 12 months from the date of the *Doctor's Statement*.

***Doctor's Statement*** means a written medical opinion of a Doctor currently licensed to practice in the United States which:

1. is made at *Your* expense; and
2. indicates that *You* have a *Terminal Condition*; and
3. includes all medical test results, laboratory reports, and any other information on which the medical opinion is based; and
4. indicates *Your* expected remaining life span; and
5. is acceptable to *Us*.

***The Accelerated Death Benefit Payment***

*We* will pay the benefit during *Your* lifetime if *You* are diagnosed with a *Terminal Condition* if *You* or *Your* legal representative submits a claim for an *Accelerated Death Benefit* and provides satisfactory proof. The benefit will be paid in one sum to *You*. There is no cost for an *Accelerated Death Benefit*.

At the time of the payment of the *Accelerated Death Benefit, We* will send a statement to the certificate holder specifying the amount of benefits paid, the effect of the *Accelerated Death Benefit* payment on the death benefit face amount, and the amount of benefits remaining available for acceleration.

***Are there any exceptions to the payment of the Accelerated Death Benefit?***

The *Accelerated Death Benefit* will not be payable:

1. for any amount of group term life insurance which is less than the Minimum ADB Payment as set forth in the *Schedule of Benefits*; or
2. if *Your Terminal Condition* is the result of:
   a. attempted suicide, while sane or insane; or
   b. intentionally self-inflicted injury; or
3. if *Your* group term life insurance benefit has been assigned; or
4. if *Your* group term life insurance benefit is payable to an irrevocable beneficiary, including notification to *Us* that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement; or
5. to retirees.

***Notice and Proof of Claim***

*You* must elect the *Accelerated Death Benefit* in writing on a form that is acceptable to *Us*. *You* must furnish proof that *You* have a *Terminal Condition*, including a *Doctor's Statement* within 91 days of the notice of claim. If proof is not given within 91 days, the claim will not be reduced or denied if proof is given as soon as reasonably possible.

***Effect on Insurance***

The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon *Your* death. When the *Accelerated Death Benefit* is paid:

1. the term life insurance benefit otherwise payable upon *Your* death will be reduced by the amount of the *Accelerated Death Benefit*. Any portion of the death benefit remaining after reduction of the death benefit due to payment of an *Accelerated Death Benefit* shall be paid upon the death of the *Insured.*
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

The payment of an *Accelerated Death Benefit* and the balance of the death benefit under the *Policy* shall constitute full settlement of the face amount of the *Policy*.
00020 TX

***What happens to my coverage if I recover from the Terminal Condition?***

If *Your Doctor* certifies that *You* no longer have a *Terminal Condition* and:

1. *You* return to work in an eligible class, coverage will remain in force, provided premium is paid when due.
2. *You* do not return to an eligible class but *You* are approved for continued life insurance coverage under the Waiver of Premium provision, coverage will remain in force, subject to the terms and conditions of the Waiver of Premium provision.
3. *You* do not return to an eligible class, and *You* do not qualify for continued life insurance, coverage will end and *You* may elect Portability or apply for conversion to an individual policy of life insurance in accordance with the applicable terms, conditions and time limits set forth in the Conversion of Life Insurance provision of the *Policy*.

In any event, the amount of coverage eligible to be continued, ported or converted will be reduced by the amount of the *Accelerated Death Benefit* paid.
00021

# *PORTABILITY BENEFIT*

***What is the Portability Benefit?***

If *Your* Supplemental Group Life Insurance, or any portion of it, terminates, *You* may elect to continue *Your* Life Insurance in accordance with the terms of the *Policy* by paying premiums directly to *Us*. If *You* elect Portability, *You* may also elect to continue *Dependent* Life Insurance under the conditions set forth below, but *You* may not apply for *Dependent* Life Insurance at the time you apply for Portability. The coverages eligible for Portability and the Portability Benefit Duration are set forth in the *Schedule of Benefits*.

The premiums for the coverage continued under the Portability Benefit will not be the same as the premium *You* are charged for *Your* group Life insurance under the *Policy*. Portability premium will be based on:

1. *Our* current rates for the applicant's age and class of risk at the time he elects Portability; and
2. the amount of insurance continued under Portability.

The maximum amount of Life Insurance which may be continued under Portability is the amount of Life Insurance terminating at the time the Portability Benefit is elected.

A beneficiary designation on the Application for Portability, if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the *Policy*, and that beneficiary designation will only apply while *Your* coverage continues under this Portability Benefit provision.

The Waiver of Premium is not available for any *Insured* whose *Total Disability* begins after coverage under Portability becomes effective. The Accelerated Death Benefit is not available for any *Insured* who is diagnosed with a *Terminal Condition* after coverage under Portability becomes effective.

***What are Eligibility Requirements for Employee Portability?***

To be eligible for Portability, *You* must meet the following conditions:

1. *You* must have been insured under the *Policy* for at least one year prior to electing Portability; and
2. *Your* Life Insurance, or a portion of it, must have terminated for reasons other than *Sickness, Injury*, retirement or termination of the master *Policy*; and
3. *You* must be less than 65 years of age; and
4. *You* must be able to perform the *Material and Substantial* duties of any *Gainful Occupation* for which *You* are qualified by education, training or experience; and
5. *You* must not have exercised the right to convert under the Conversion of Life Insurance provision the amount of Life Insurance *You* elect under the Portability Benefit. If *You* elect the Portability benefit, any amounts of Life Insurance which are not ported may be converted in accordance with the terms of the Conversion of Life Insurance provision.

*You* must submit an application for Portability and the first premium within 31 days after the date *Your* Life Insurance terminated.

*We* reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* misrepresented any of the information provided to support eligibility for Portability.

***Can Dependent Life Insurance be Ported if Your Eligibility Terminates or if Your Spouse's Coverage Terminates?***

Yes, *You* or *Your* insured *Spouse* may elect Portability of Dependents' Life Insurance if Dependents' insurance coverage ceases as follows:

1. *You* may apply for Portability of Dependent Life Insurance if *You* meet the eligibility requirements to port *Your* Life Insurance as shown above and *You* are covered for Dependent Life insurance on the date *Your* coverage ceases.
2. *Your* insured *Spouse* may apply for Portability of his Group Life Insurance, and/or life insurance on covered *Dependent Child*(ren) provided:
    a. *Your Spouse*'s life insurance terminates because *You* die or *Your* eligibility for Dependent Life Insurance ceased for reasons other than retirement or termination of the master *Policy* and *Your Spouse* is less than 65 years of age.

b. *Your Spouse* had elected Dependent Life on eligible *Dependent Child(ren)* and such coverage is still in force when *Your* eligibility for Dependents Life Insurance ceased for reasons other than retirement or termination of the master *Policy*.

c. *Your Spouse* must have been insured for such coverage(s) under the *Policy* for at least one year prior to electing Portability.

d. Portability is not available if *Your Spouse's* life insurance terminates because he no longer meets the *Policy* definition of an *Eligible Dependent Spouse*.

3. *You* or *Your Spouse* must not have exercised the right to convert under the Dependent Conversion Privilege provision of the *Policy* the amount of coverage *You* or *Your Spouse* elect under the Portability Benefit. If *You* elect portability of Dependent Life Insurance, any amounts of Dependent Life Insurance which are not ported may be converted in accordance with the terms of the *Policy*.

If these criteria are met, *You* or *Your Spouse*, must submit an Application for Portability and the first premium within 31 days after the date such eligible Dependent Life Insurance terminated.

*We* reserve the right to rescind any coverage amounts continued under Portability if it can be shown that *You* or *Your Spouse* misrepresented any of the information provided to support eligibility for Portability of Dependent Life Insurance.

***When will Portable Coverage Terminate?***

Insurance continued under the Portability Benefit provision of the *Policy* will terminate at the earliest of the following:

1. the date *You* return to work with the *Policyholder* while the *Policy* is still in force; or
2. the date *You* or *Your Spouse* fail to pay the required premiums when due; or
3. the end of the Portability Benefit Duration set forth in the *Schedule of Benefits*; or
4. the premium due date following the date a Dependent ceases to meet the definition of an *Eligible Dependent*.

If continuation of life insurance under the Portability Benefit provision ceases while the *Policy* is still in force, and *You* are employed by the *Policyholder*, *Your* life insurance will continue provided premium payments begin on the next premium due date. If *You* return to work with the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, we will pay death benefits according to the Facility of Payment provision.

***Is Conversion available after coverage under Portability ends?***

If coverage under Portability terminates according to (3) or (4) above, *You* may convert to an individual policy of whole life insurance in accordance with the terms of the Conversion provisions of the *Policy*. No *Evidence of Insurability* will be required. The amount of the conversion policy may not exceed the amount of life insurance which terminated as set forth above.

00022

# *DEPENDENT LIFE INSURANCE*

***THIS BENEFIT ONLY APPLIES IF YOU HAVE ELECTED DEPENDENT TERM LIFE INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.***

***What is the Dependent Life Insurance Benefit?***

*We* will pay *You* the amount of insurance set forth in the *Schedule of Benefits* on the life of *Your Dependent*(s) while *Your* insurance is in force. Payment will be in one lump sum.

If *You* are not living at the time *Dependent* life insurance benefits become payable, *We* will pay the benefit:

1. to *Your Spouse*, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and sisters, if living; otherwise
5. to *Your* estate.

***Are Life Insurance Benefits payable for death by suicide?***

Life Insurance benefits will not be payable for a loss caused by suicide or attempted suicide, while sane or insane, within one (1) year from the effective date of *Your* covered *Dependent*'s *Supplemental* Term Life Insurance or the effective date of any increased amount of life insurance. *Our* liability for a death claim by suicide will be limited to the return of premium paid for this life insurance.

If *Your* covered *Dependent*(s):

1. were covered for *Voluntary* life insurance under a prior carrier's policy;
2. were insured under the *Policy* on its effective date; and
3. and there was no lapse in coverage,

We will consider the time *Your* covered Dependent(s) were covered under the *Policy* and under the prior carrier's policy in determining if benefits are payable for death by suicide. The death benefit, if payable under this provision, will be the lesser of the benefit under the *Policy* or the benefit under the prior carrier's policy.
00023

***Who is eligible for Dependent Life Insurance?***

If *You* are insured for life insurance under the *Policy* and belong to a class listed in the *Schedule of Benefits* as eligible for *Dependent* Life Insurance benefits, *You* are eligible to enroll for this benefit. If *You* or *Your Spouse* are enrolled for *Dependent* Life Insurance and subsequently acquire a new *Eligible Dependent*, that *Dependent* will automatically be covered.

Note: No eligible person may be covered more than once under the *Policy*. If a person is covered as an *Employee*, he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee*. If both parents are covered as insured *Employees* under the *Policy*, only one may enroll for life insurance coverage on *Eligible Dependent Child*(ren).

***When does Dependent Life Insurance become effective?***

Provided *You*:

1. have completed any required *Employee Eligibility Waiting Period*; and
2. apply for *Dependent* Life Insurance no later than 31 days after becoming eligible for this benefit; and
3. have paid or are obligated to pay any applicable premium.

Life insurance for *Your Eligible Dependent(s)* will become effective on the later of:

1. the date *Your* group insurance coverage becomes effective;
2. the effective date of the *Dependent* Life Insurance benefit;
3. the first of the month that falls on or next follows date *You* enroll *Your Eligible Dependent(s)*;

4. the first of the month that falls on or next follows the date *You* acquire *Your Eligible Dependent(s)*; or
5. if *Evidence of Insurability* is required, the date *We* determine that evidence is satisfactory and *We* provide notice of approval.

If *You* enroll for *Dependent* Life Insurance more than 31 days after *You* are eligible to do so, *You* must furnish *Evidence of Insurability* satisfactory to *Us* for each *Dependent*, and coverage will become effective as set forth above.

If an *Eligible Dependent* is required to submit satisfactory *Evidence of Insurability* for any reason, insurance in the amount for which *We* require such evidence will become effective on the date *We* determine that the evidence is satisfactory and *We* provide notice of approval.

If an *Eligible Dependent* is *Hospital Confined* or *Your* eligible *Spouse* is unable to perform two of the *Activities of Daily Living* on the date coverage would otherwise become effective, insurance will not become effective until the date the *Eligible Dependent* is *No Longer Hospital Confined* or *Your Spouse* is able to perform at least two of the *Activities of Daily Living.*

***When do changes in the Dependent Life Insurance benefit become effective?***

If no *Evidence of Insurability* is required, increases in the amount of *Dependent* Life Insurance will become effective immediately on the date of the change, provided the *Dependent* is not *Hospital Confined* on that day. If the *Dependent* is *Hospital Confined*, the increase will become effective on the date the *Dependent* is *No Longer Hospital Confined*.

For amounts on which *Evidence of Insurability* is required, increases in the amount of Dependent Life Insurance will be effective on the date *We* determine that evidence is satisfactory; and, *We* provide notice of approval.

Any decrease in the amount of *Dependent* Life Insurance will become effective immediately on the date of the change.
00024

**Definitions which apply to the Dependent Life Insurance provision:**

***Eligible Dependent means:***

1. the *Spouse* of each individual eligible to be insured under the *Policy*;
2. a natural or adopted child of each individual eligible to be insured under the *Policy* if the child is:
   a. younger than 26 years of age; or
   b. physically or mentally disabled and under the parents' supervision; or
3. a natural or adopted grandchild of each individual eligible to be insured under the *Policy* if the child is:
   a. younger than 26 years of age; and
   b. a dependent of the *Insured* for federal income tax purposes at the time the application for coverage of the child is made.
4. *Your* step child if the child is:
   a. meets the qualifications of a natural child; and
   b. is living in *Your* home; and
5. *Your* foster child if the child is:
   a. meets the qualifications of a natural child; and
   b. is living in *Your* home; and

***Dependent Child -*** *See Dependent or Eligible Dependent*

***No Longer Hospital Confined*** means the *Eligible Dependent* has been discharged from a hospital, nursing home or other medical facility which provides skilled medical care. This provision does not apply to *Your Dependent Child* born while *You* are insured under the *Policy* or covered under the prior policy.

***Spouse*** means lawful spouse.
00026 TXb

## *CONVERSION OF DEPENDENT LIFE INSURANCE*

***Can Dependent Life Insurance be converted if Eligibility Terminates?***

Yes, a *Dependent* may convert to an individual policy of life insurance if his Life Insurance, or any portion of it, ceases because:

1. *You* are no longer employed by the *Policyholder*; or
2. *You* are no longer in a class which is eligible for *Dependent* Life Insurance; or
3. *You* die; or
4. a *Dependent Child* reaches the limiting age under the Policy; or
5. a *Dependent Spouse* is no longer eligible as a result of divorce or dissolution of marriage; or
6. a *Dependent* is no longer eligible as defined in this provision.

In any of these situations, the *Dependent* may convert up to the amount which was in force on the date insurance was terminated.

***How much can Your covered Dependent convert if the Policy is terminated or amended?***

A *Dependent* may also convert to an individual policy of life insurance if his Life Insurance ceases because:

1. *Dependent* Life Insurance benefits under the *Policy* cease; or
2. the *Policy* is amended making the insured *Dependent* ineligible for *Dependent* Life Insurance; however, he must have been insured under the *Policy*, or the policy it replaced, for at least five (5) years.

The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which the *Dependent* becomes eligible under this or any other group policy within 31 days after the date his life insurance ceased; or
2. $10,000.

***How to apply for conversion***

*We* must receive written application and the first premium for the individual life insurance policy within 31 days after life insurance under the *Policy* ceases. No *Evidence of Insurability* will be required.

The individual policy will be a policy of whole life insurance. It will not contain Accidental Death and Dismemberment benefits or any other supplementary benefits.

The minimum issue amount of an individual conversion policy is $2,000. The premium for the individual policy will be based on:

1. *Our* current rates based upon the applicant's attained age; and
2. the amount of the individual policy.

If the *Dependent* applies for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which he could apply for conversion.

If the *Dependent* dies during a period when he would have been entitled to have an individual policy issued to him and if he dies before such an individual policy became effective, *We* will pay the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. the death occurred during the 31-day period during which he could have made application; and
2. *We* receive *Proof* of death.

If life insurance benefits are paid under the *Policy*, payment will not be made under the converted policy, and *We* will refund any premiums paid for the converted policy.

If *You* have elected *Dependent* Life Insurance under the Portability Benefit, conversion is not available unless coverage under Portability terminates. Conversion from Portability will be as specified under Portability.
00027 TX

# *ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)*

***THIS BENEFIT ONLY APPLIES TO YOU IF YOU HAVE ELECTED AD&D INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.***

***COVERAGE PLANS AVAILABLE***

Note: No eligible person may be covered more than once under the *Policy*. If a person is covered as an *Employee*, he cannot be covered as a *Spouse* or *Dependent Child* of another *Employee*. If both parents are covered as insured *Employees* under the *Policy*, only one may enroll for life insurance coverage on *Dependent Child(ren)*.
00029

***What is the AD&D Benefit?***

If, while insured under the *Policy*, *You* or *Your* covered Dependent suffer an *Injury* in an *Accident, We* will pay for those *Losses* set forth in the "Table of Losses" below. The amount paid will be the percentage stated in the Table of Losses but not more than the Coverage Amount set forth in the *Schedule of Benefits*. 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.

| TABLE OF LOSSES | % OF COVERAGE AMOUNT PAYABLE |
|---|---|
| Loss of Life | 100% |
| Loss of Both Hands | 100% |
| Loss of Both Feet | 100% |
| Loss of Entire Sight of Both Eyes | 100% |
| Loss of One Hand and One Foot | 100% |
| Loss of Speech and Hearing | 100% |
| Quadriplegia | 100% |
| Paraplegia | 75% |
| Loss of One Hand | 50% |
| Loss of One Foot | 50% |
| Loss of Entire Sight of One Eye | 50% |
| Loss of Speech | 50% |
| Loss of Hearing (both ears) | 50% |
| Hemiplegia | 50% |

| | |
|---|---|
| Loss of Thumb and Index Finger (on same hand) | 25% |
| Uniplegia | 25% |

**Definitions which apply to the AD&D Provision:**

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

***Hemiplegia*** means total *Paralysis* of one arm and one leg on the same side of the body.

***Loss***, with respect to hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, speech and hearing, loss means entire and irrecoverable loss of sight, speech or hearing. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

***Paralysis*** means loss of use without severance of a limb as a result of an *Injury* to the Spinal Cord, which has continued for 12 months. *Paralysis* must be determined by a *Doctor* to be permanent, total and irreversible.

***Paraplegia*** means total *Paralysis* of both legs.

***Quadriplegia*** means total *Paralysis* of both arms and both legs.

***Uniplegia*** means total *Paralysis* of one limb.

The total amount of AD&D benefits payable for all *Losses* for any *Insured* resulting from any one *Accident* will not be greater than the Coverage Amount set forth in the *Schedule of Benefits*.

Except as provided in a particular AD&D benefit provision, *We* will pay benefits for loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other *Losses* will be paid to *You*.
00030

## *SEAT BELT BENEFIT*

***What is the Seat Belt Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits*, if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* were driving or riding in an *Automobile*, if:

1. the *Automobile* is equipped with *Seat Belts*.
2. the *Seat Belt* was in actual use and properly fastened at the time of the *Accident*.
3. the position of the *Seat Belt* is certified in the official report of the *Accident* or by the investigating officer. A copy of the police accident report must be submitted with the claim.
4. *You* were driving or riding in an *Automobile* driven by a licensed driver who was neither:
    a. intoxicated or driving while impaired. Intoxication and impairment shall be determined, with or without conviction, by the law of the jurisdiction in which the Accident occurs or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication; nor
    b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If the required certification is not available and if it is unclear whether *You* were properly wearing a *Seat Belt*, then *We* will pay an additional benefit of $1,000.

***Automobile*** means a validly registered private passenger car (or policyholder-owned car), station wagon, jeep-type vehicle, SUV, pick-up truck or van-type car that is not licensed commercially or being used for commercial purposes.

***Seat Belt*** means those belts that form an occupant restraint system.
00031

## *AIR BAG BENEFIT*

***What is the Air Bag Benefit?***

*We* will pay an additional amount as set forth in the *Schedule of Benefits* if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* are driving or riding in an *Automobile* provided that:

1. *You* were positioned in a seat that was equipped with an *Air Bag*;
2. *You* were properly strapped in the *Seat Belt* when the *Air Bag* inflated; and
3. the police report establishes that the *Air Bag* inflated properly upon impact.

If it is unclear whether *You* were properly wearing *Seat Belt*(s) or if it is unclear whether the *Air Bag* inflated properly, then the Air Bag Benefit will be $1,000.

***Air Bag*** means an inflatable supplemental passive restraint system installed by the manufacturer of the *Automobile*, or proper replacement parts as required by the automobile manufacturer's specifications, that inflates upon collision to protect an individual from injury and death. A *Seat Belt* is not considered an *Air Bag*.
00032

## *REPATRIATION BENEFIT*

***What is the Repatriation Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits,* for the preparation and transportation of *Your* body to a mortuary if:

1. the Coverage Amount under the AD&D Benefit is payable for *Your* loss of life; and
2. *Your* death occurs at least 75 miles away from *Your* principal residence.

00033

## *EDUCATION BENEFIT*

***What is the Education Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits* to *Your Dependent Student* if an AD&D benefit is payable for *Your* loss of life. *We* will only pay one Education Benefit to any one *Dependent Student* during any one school year. If the *Dependent Student* is a minor, *We* will pay the benefit to the legal representative of the minor.

**Definitions which apply to the Education Benefit:**

***Student*** means an *Eligible Dependent* child who, on the date of *Your* death, is:

1. A full-time post-high school student in a *School of Higher Education*; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a *School of Higher Education* within 365 days after *Your* death.

***School of Higher Education*** 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.

**When Benefit Ends:** A *Dependent Student* will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. *Our* payment of the fourth installment of the Dependent Education Benefit on behalf of or to the *Dependent Student;* or

2. At the end of the period during which due *Proof* must be submitted if no due *Proof* is submitted.

**Special Child Education Benefit:** If *Your Eligible Dependent* child does not qualify as a *Student*, but is enrolled in an elementary or high school, *We* will pay a Child Education Benefit in the amount of $1,000. This benefit is payable once upon proof that *You* died as a result of an Accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after *Your* death, *Your Eligible Dependent Child* is a full-time student in an elementary or high school.

00034

## *SPOUSE TRAINING BENEFIT*

***What is the Spouse Training Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits*, to *Your Dependent Spouse* if the coverage amount under the AD&D Benefit is payable for *Your* loss of life. The benefit payable is up to the Maximum Spouse Training Benefit set forth in the *Schedule of Benefits*. The benefit is paid annually for the cost of covered expenses incurred within 36 months of *Your* death.

*We* will pay this benefit if *You*:

1. die within 365 days of and as a result of a covered *Accident;* and
2. are survived by a *Spouse*.

The benefit will be payable for *Your* surviving *Spouse* who:

1. enrolls within 365 days after *Your* death in any *School of Higher Education* for the purpose of training, retraining or refreshing skills needed for employment; and
2. incurs expenses payable directly to or approved and certified by such school.

***School of Higher Education*** 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.

00035

## *DAY CARE BENEFIT*

***What is the Day Care Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits*, if the *Employee* Coverage Amount under the AD&D Benefit is payable for *Your* loss of life. The benefit is paid annually for the cost of covered expenses incurred, if *You* are survived by a *Dependent Child* who:

1. on the date of the covered *Accident* was enrolled in a legally licensed *Day Care Center*; or
2. is enrolled in a legally licensed *Day Care Center* within 365 continuous days from the date of the covered *Accident;* and
3. is less than 13 years of age.

The Day Care Center Benefit is payable for incurred *Day Care Center* expenses for each child who qualifies:

1. in an amount up to the Day Care Benefit Amount as set forth in the Schedule of Benefits ; and
2. only while the *Dependent* child continues to be enrolled in a legally licensed *Day Care Center*.

*We* will pay this benefit once a year, at the end of a 12-month period in which there are documented *Day Care Center* expenses, for not more the Maximum Day Care Benefit Duration, as set forth in the *Schedule of Benefits*, or until the child's 13th birthday, whichever happens first.

If at the time of the *Accident*, coverage for a *Dependent Child* is in force, but there is no *Dependent* child who qualifies, we will pay an additional benefit of $1,500 to *Your* designated beneficiary.

This benefit will be payable to *Your* surviving *Spouse*, if *Your Spouse* has custody of the child. If *You* have no surviving *Spouse*, or *Your* child does not live with *Your Spouse*, then the benefit will be paid to the child's legally appointed guardian.

***Day Care Center*** means a facility which is run according to law, including laws and regulations applicable to child care facilities, and which provides care and supervision for children in a group setting on a regular, daily basis.

A *Day Care Center* does not include: a hospital, the child's home or care provided during normal school hours while a child is attending grades one through twelve.
00036

## *COMA BENEFIT*

***What is the Coma Benefit?***

*We* will pay an additional amount, as set forth in the *Schedule of Benefits*, if *You* become *Comatose* as a result of a covered *Accident* within 31 days of the *Accident* and remain *Comatose* beyond the *Waiting Period*.

*We* will pay the Coma Benefit as shown on the *Schedule of Benefits* each month from the end of the *Waiting Period*. *We* will cease payment on the earliest of:

1. the end of the month in which *You* die;
2. the end of the Coma Maximum Benefit Duration; or
3. the end of the month in which *You* are no longer *Comatose*.

If *You*:

1. die from any cause or as a result of the covered *Accident* while this Coma Benefit is payable; or
2. remain *Comatose* after this Coma Benefit is payable for the Coma Maximum Benefit Duration, we will pay a lump sum benefit equal to the Coverage Amount payable under the Policy for *Accidental* death, reduced by the amount of any *Accidental* dismemberment, loss of sight, speech, hearing, paralysis or Coma benefits paid to *You* for the *Loss* caused by the covered *Accident*.

***Coma*** or ***Comatose*** means a state of complete loss of consciousness from which *You* cannot be aroused and there is no evidence of response to stimulation.

***Waiting Period*** for the purpose of this benefit means the 31 day period from the date *You* become *Comatose*.

**Exclusion**: In addition to the Limitations set forth in this Certificate, the following exclusion applies to this Coma Benefit: Benefits will not be paid for loss covered by or resulting from sickness, disease, bodily infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Bacterial infection that is the natural and foreseeable result of an *Accidental Injury* or *Accidental* food poisoning is not excluded.
00041

## *EXPOSURE AND DISAPPEARANCE*

If, as a result of an *Accident* while insured for this benefit, if *You* or *Your Insured Dependents* are unavoidably exposed to the elements and suffer a *Loss* as a result of that exposure, that *Loss* will be covered. If *Your* or *Your Insured Dependents* body has not been found within one (1) year of an *Accidental* disappearance, forced landing, sinking or wrecking of a conveyance in which *You* or *Your Insured Dependents* were occupants, *You* or *Your Insured Dependents* will be deemed to have suffered loss of life.
00043

## *LIMITATIONS*

***Are there any Limitations for losses due to an Accident?***

*We* will not pay any benefit for any *Loss* that, directly or indirectly, results in any way from or is contributed to by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except a pus-forming infection of an *Accidental* cut or wound; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. war, declared or undeclared, whether or not *You* or *Your Insured Dependent* is a member of any armed forces; or

6. travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
7. commission of, participation in, or an attempt to commit an assault or felony; or
8. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
9. intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
10. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

00050

## *UNIFORM PROVISIONS*

*(Applicable to Dismemberment Coverage Only)*

***Initial Notice of Claim***

*We* must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

***Claim Forms***

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant 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 the *Loss*.

***Time Limit for Filing Your Claim***

*We* must receive written *Proof* of *Loss* within 91 days after the date a *Loss* is incurred. 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 the claimant is legally incapacitated, written *Proof* of *Loss* must be given no later than one year after the time *Proof* is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time *Proof i*s due. However, benefits may be paid for late claims if it can be shown that:

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

For the Education Benefit, *Proof* of *Loss* must:

1. Include *Proof* of *Dependent Student* status; and
2. Be submitted no later than
    a. Two months after completion of course work for that particular school year if the *Dependent Student* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall be deemed to begin on September 1st and end on August 31st; or
    b. Within six (6) months after enrollment in a *School of Higher Education* if the *Dependent Student* is in the 12th grade at the time of *Your* death.

After the first year in a *School of Higher Education*, due *Proof* must be submitted in accordance with the time limits defined in Item (a) above.

***Physical Examination/Autopsy***

Upon receipt of a claim, *We* may examine an *Insured*, at *Our* expense, at any reasonable time. *We* reserve the right to perform an autopsy, at *Our* expense, if it is not prohibited by any applicable local law(s).
00051 TX

# *TERMINATION PROVISIONS*

***When does Your coverage under the Policy end?***

*Your* coverage will terminate on the earliest of the following dates. Termination will not affect *Your* claim for a covered *Loss* which occurred while the coverage was in force.

1. the date on which the *Policy* is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; 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. are no longer *Actively at Work* as a result of a disability, layoff, leave of absence, or military leave. However, *You* may continue to be eligible for group insurance coverage, as follows:

| | |
|---|---|
| **Disability** | Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group life insurance provided by a new carrier. |
| **Layoff** | Until the end of the month following the month during which the layoff began, provided all premiums are paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group life insurance provided by a new carrier. |
| **Leave of Absence** | Until the end of the month following the month during which the leave began, or, the period of time in accordance with the FMLA provision below, provided all premiums are paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group life insurance provided by a new carrier. |
| **Military Leave** | Until the end of the twelfth month following the month in which the military leave began, provided all premiums are paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group life insurance provided by a new carrier. |

For the purposes of this Termination Provision only, *Disability* means *You* are unable to perform all of the *Material* and *Substantial Duties* of *Your Regular Occupation.*
00052TXa

***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, the *Policy* is in force and *Your* coverage is not replaced with group life insurance provided by a new carrier, *Your* 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.

*You* are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a *Spouse,* child or parent due to their serious illness; or
5. For *Your* own serious health condition.

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 *Your* agreement with the *Policyholder*.

00053a

***When does Dependent Life Insurance coverage end?***

Unless Life and AD&D insurance is continued under the Portability Benefit provision, *Dependent* Life Insurance coverage will end on the earliest of:

1. the date *You* are no longer *Actively at Work* (except in the case of disability, layoff or leave of absence as set forth above); or
2. the date on which the *Policy* is terminated;
3. the date *You* stop making any required contribution toward payment of premiums;
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. 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
6. the date a *Dependent Child* or *Spouse* no longer meets the *Policy* definition of *Eligible Dependent.*

Note: Coverage will continue past the age limit for eligible *Dependent Children* who are primarily dependent upon *You* for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. *Proof* of such incapacity must be provided to *Us* upon request.

00054 TX

# *GENERAL PROVISIONS*

***Entire Contract; Changes***

The *Policy*, the *Policyholder's Application*, the *Employee's* Certificate of coverage, and *Your* 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 his signed *Application*; or
2. any *Employee* in applying for insurance under the *Policy* will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the *Employee*, is or has been given to the *Employee.*

***Legal Actions***

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

1. until 60 days after *Proof* of claim has been given; or
2. more than 3 years after *Proof* of *Loss* 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.

***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.

***Premium Provisions***

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* has agreed to deduct from *Your* pay any premiums payable for *Your Supplemental* coverage. The *Policyholder* agrees to remit such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. 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.

***Misstatement of Age***

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

***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.

***Assignment***

*You* may assign any incident of ownership *You* may possess of the Life Insurance benefits provided under the *Policy* to anyone other than the *Policyholder*. *We* are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

***Retention of Discretion***

*We* shall have the exclusive right to interpret the terms of the Certificate, *Schedule of Benefits*, Riders and Endorsements. The decision about whether to pay any claim, in whole or in part, is within *Our* sole discretion and such decisions shall be final and conclusive.

00055 TX

# *DEFINITIONS*

**This section tells *You* the meaning of special words and phrases used in this Certificate. To help *You* recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.**

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

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

*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); and
7. *You* were not *Hospital Confined* or disabled due to an *Injury* or *Sickness*.

00061

***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).

00062

***Annual Enrollment Period*** means a period of time prior to the *Policy* anniversary date during which eligible *Employee*s may apply for *Supplemental* life coverage or request changes to their life benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

00064

***Application*** means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.

00066

***Coma*** or ***Comatose*** means a state of complete loss of consciousness from which *You* cannot be aroused and there is no evidence of response to stimulation.

00069

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

00070

***Dependent or Eligible Dependent*** means:

1. the *Spouse* of each individual eligible to be insured under the *Policy*;

2. a natural or adopted child of each individual eligible to be insured under the *Policy* if the child is:
    a. younger than 26 years of age; or
    b. physically or mentally disabled and under the parents' supervision; or
3. a natural or adopted grandchild of each individual eligible to be insured under the *Policy* if the child is:
    a. younger than 26 years of age; and
    b. a dependent of the *Insured* for federal income tax purposes at the time the application for coverage of the child is made.
4. *Your* step child if the child is:
    a. meets the qualifications of a natural child; and
    b. is living in *Your* home; and
5. *Your* foster child if the child is:
    a. meets the qualifications of a natural child; and
    b. is living in *Your* home; and

***Dependent Child*** **-** See *Dependent* or *Eligible Dependent*
00072 TXb

***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 *Total Disability*, *Terminal Condition* or covered *Loss*, and the treatment provided by the practitioner is within the scope of his or her license.
00073

***Doctor's Statement*** means a written medical opinion of a *Doctor* currently licensed to practice in the United States which:

1. is made at *Your* expense; and
2. indicates that *You* have a *Terminal Condition*; and
3. includes all medical test results, laboratory reports, and any other information on which the medical opinion is based; and
4. indicates *Your* expected remaining life span; and
5. is acceptable to *Us*.

00125 TX

***Employee*** means an *Actively at Work* full-time 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 the minimum hours per week as set forth in the *Schedule of Benefits* and is reported on the *Policyholder*'s records for Social Security and withholding tax purposes.
00074

***Gainful Occupation*** means any work or employment in which the insured *Employee*:

1. is or could reasonably become qualified, considering his or her education, training, experience, and mental or physical abilities;
2. could reasonably find work or employment, considering the demand in the national labor force; and
3. could earn (or reasonably expect to earn) a before-tax income at least equal to 60% of his or her pre-disability income.

00078

***Hospital Confined*** means that, upon the recommendation of a *Doctor*, *You* are registered as an inpatient in a hospital, nursing home or other medical facility which provides skilled medical care or as an outpatient in a hospital because of surgery. *You* are not *Hospital Confined* if *You* are receiving emergency treatment or if *You* are hospitalized solely because of non-surgical medical or diagnostic test.
00081

***Injury*** means bodily injury resulting directly from an *Accident* and independently of all other causes.
00082

***Insured*** means an *Employee* or *Eligible Dependent* covered under the *Policy.*
00083

***Male Pronoun*** whenever used includes the female.
00088

***Material and Substantial Duties*** means duties that are normally required for the performance of *Your Regular Occupation* and cannot be reasonably omitted or modified.
00089

***Non-Contributory*** means the *Policyholder* pays 100% of the premium for this insurance.
00092

***Policy*** means this contract between the *Policyholder* and Us including the attached *Application*, which provides group insurance benefits.
00097

***Policyholder*** means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*.
00098 TX

***Proof*** under the Accelerated Death Benefit means evidence satisfactory to *Us* that *You* have a *Terminal Condition*.
00100a TX

***Regular Occupation*** means the occupation that *You* are routinely performing when *Your* Life Insurance terminates due to *Disability*. *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.
00105

***Sickness*** means illness, disease, pregnancy or complications of pregnancy.
00109

***Supplemental*** means coverage for which *You* pay 100% of the premium.
00114

***We, Our*** and ***Us*** means Dearborn Life Insurance Company, Chicago, Illinois.
00119

***You, Your*** and ***Yours*** means the eligible *Employee* to whom this Certificate is issued and whose insurance is in force under the terms of the *Policy.*
00120

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

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

**RIDER**

This Rider is made a part of the Policy or Certificate (hereafter "the Policy") to which it is attached. It takes effect and ends at the same time as the Policy. All provisions of the Policy, including any other Riders or Amendatory Endorsements will apply to this Rider, except that in the event of a conflict, the specific provisions of this Rider will govern.

## Beneficiary Resource Services

***What is the Beneficiary Resource Services?***

The Beneficiary Resource Services is a non-insurance benefit made available to ***You*** or ***Your*** beneficiaries which provides access at no additional cost to the following services.

- Unlimited telephone access to grief counselors, legal advisors and financial advisors for up to one year from the date of loss; and,
- Five (5) face-to-face sessions, or equivalent professional time, with a grief counselor, legal advisor and/or a financial advisor for up to one year from the date of loss.

***How the Beneficiary Resource Services are accessed***

***You*** or ***Your*** beneficiaries may access these services by contacting LifeWorks at 1- 800-769-9187, the program administrator for *Beneficiary Resource Services*. Additional contact information will be provided at the time a claim for a loss covered under the Policy is made. Dearborn Life Insurance Company does not underwrite or administer the *Beneficiary Resource Services* program.

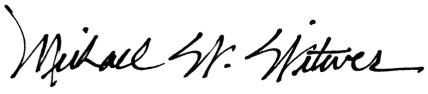
***When do the Beneficiary Resource Services Terminate?***

The services available under this Rider will end as follows:

- On the date ***Your*** coverage is terminated under the section *When Does Your coverage under the Policy end?* found in the Termination Provision of the Policy; or
- One year from the date of loss if the loss occurs while the Policy is in effect.

***Important Terms***

For purposes of this Rider, "date of loss" means the date of death of the named insured or the date the named insured became eligible for benefits under the Accelerated Death Benefit provision of the Policy to which this Rider is attached. If the named insured becomes eligible for and receives benefits under the Accelerated Death Benefits provision of the Policy, and subsequently dies, the date of loss remains the date the named insured became eligible for benefits under the Accelerated Death Benefit provision of the Policy to which this Rider is attached.



President

Nothing contained in this Rider shall be held to alter or affect any provision or condition of the Policy other than as stated above.

***NOTICE***

***to***

***the Policyholder and Certificateholder Insured under***

***the Group Term Life Insurance Policy***

***Provided by Dearborn Life Insurance Company***

***Regarding the Beneficiary Resource Services Noninsurance Benefit***

This notice is to advise you that Your Group Term Life Insurance program also provides a non-insurance benefit: *Beneficiary Resource Services*.

**Noninsurance Benefit Description**

Beneficiary Resource Services is a service that provides unlimited telephone access to grief counselors, legal advisors and financial advisors, as well as five (5) face-to-face sessions for up to one year following the date of loss. (Date of loss is defined in the Beneficiary Resource Services Rider attached to the Policy.)

This noninsurance benefit is available at the option of the Policyholder without any action required on the part of an insured person to either accept or decline the service.

There is no charge for this service.

The service is currently administered by LifeWorks.

Dearborn Life Insurance Company (sometimes referred to as "We" or "Our") makes this program available, but it does not underwrite or administer the Beneficiary Resource Services program.

**Why This Service is Being Made Available**

We are making this service available to provide support and assistance to persons who have suffered a loss that is covered by the group term life insurance policy. The death or terminal illness of a loved one has a significant impact and support services help deal with the grief legal or financial issues experienced during the critical months following a loss.

**Accessing Beneficiary Resource Services**

Services may be accessed by contacting the program administrator named in the Rider at 1-800-769-9187.

**Termination of the Noninsurance Benefit**

This noninsurance benefit is provided free of charge. It is subject to termination at our option or at the option of the program administrator.

If We discontinue this service We will notify the Policyholder not less than thirty (30) days in advance of the discontinuance of this service.

If the current program administrator discontinues the program and we are unable to find a replacement, we will notify the Policyholder as soon as is reasonable under the circumstances. If discontinued, the services available under this noninsurance benefit will no longer be available.

Unless terminated by Us or by the Program administrator, the Beneficiary Resource Services noninsurance benefit is available following a covered loss for as long as you remain covered under the group term life insurance policy and such policy remains in effect, subject to the time periods stated above.

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

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

**RIDER**

This Rider is made a part of the Policy or Certificate (hereafter "the Policy") to which it is attached. It takes effect and ends at the same time as the Policy. All provisions of the Policy, including any other Riders or Amendatory Endorsements will apply to this Rider, except that in the event of a conflict, the specific provisions of this Rider will govern.

## Travel Resource Services

***What is the Travel Resource Services?***

*Travel Resource Services* is a non-insurance benefit made available to ***You*** which provides access at no additional cost to the following services:

- Access to a toll free number in the event ***You*** encounter an emergency while traveling more than 100 miles from ***Your*** principal residence.
- Access to on-line tools and resources for any pre-trip assistance *You* may need.

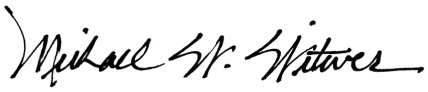
***How is Travel Resource Services accessed?***

Your employer will provide ***You*** with an identification card to be used whenever services are needed. This card will give ***You*** access to the toll-free number used to initiate the services.

The Travel Resource Services program is administered and provided by Assist America, Inc. Dearborn Life Insurance Company does not underwrite or administer this program.

***When do the Travel Resource Services terminate?***

The Travel Resource Services terminate if ***Your*** coverage is terminated under the section on *When does Your coverage under the Policy end?* found in the Termination Provision of the Policy.



President

Nothing contained in this Rider shall be held to alter or affect any provision or condition of the Policy other than as stated above.

***NOTICE***

***to***

***the Policyholder and Certificate holder under***

***the Group Term Life Insurance Policy***

***Provided by Dearborn Life Insurance Company***

***Regarding the Travel Resource Services Noninsurance Benefit***

This notice is to advise you that Your Group Term Life Insurance program also provides a non-insurance benefit: *Travel Resource Services*.

**Noninsurance Benefit Description**

Travel Resource Services is a service that provides telephonic access to emergency assistance while traveling more than one hundred (100) miles from ***Your*** home and access to on-line travel tools and resources when preparing a trip.

This noninsurance benefit is available at the option of the Policyholder without any action required on the part of an insured person to either accept or decline the service.

There is no charge for this noninsurance benefit.

The service is currently administered by Assist America, Inc.

Dearborn Life Insurance Company (sometimes referred to as "We" or "Our") makes this program available, but it does not underwrite or administer the Travel Resource Services program.

**Why This Service is Being Made Available**

We are making this service available to provide support and assistance to persons who are traveling or preparing to travel, in addition to the group life and accidental death benefits available under this Policy. If an emergency occurs on a trip, counselors are available to assist in locating nearby hospitals, assist in recovering lost passports, medical evacuations, and other emergencies. Advice at the planning stage of a trip is available.

**Accessing Travel Resource Services**

Services may be accessed by contacting the program administrator at 1-800-872-1414.

**Termination of the Noninsurance Benefit**

This noninsurance benefit is provided free of charge as a courtesy. It is subject to termination at our option or at the option of the program administrator.

If We discontinue this service We will notify the Policyholder not less than thirty (30) days in advance of the discontinuance of this service.

If the current program administrator discontinues the program and we are unable to find a replacement, we will notify the Policyholder as soon as is reasonable under the circumstances. If discontinued, the services available under this noninsurance benefit will no longer be available.

Unless terminated by Us or by the Program administrator, the Travel Resource Services noninsurance benefit is available following a covered loss for as long as you remain covered under the group term life insurance policy and such policy remains in effect.

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

**DEARBORN LIFE INSURANCE COMPANY**

**Chicago, Illinois**

# CAMPUS VIOLENCE BENEFIT RIDER

This Rider is effective September 1, 2023. It is part of the Policy or Certificate to which it is attached. It is subject to all provisions of the Policy or Certificate not in conflict with the provisions of this Rider.

## *CAMPUS VIOLENCE BENEFIT*

***What is the Campus Violence Benefit?***

*We* will pay an additional amount, as shown below, to *You*, or in the event of *Your* death, to *Your* designated beneficiary if, as the result of a violent event on Campus, *An Insured Person* suffers:

1. Loss of Life; and
2. Loss of Life is the direct result of the following;

    a. Shooting, stabbing, bombing, poisoning, aggravated assault or other similar activity directed at *Employees* or students of the *Policyholder*; and

    b. The Loss of Life is inflicted by persons other than *Employees* or members of *Your* family or household.

This benefit is payable in addition to any other benefits provided under the *Policy*.

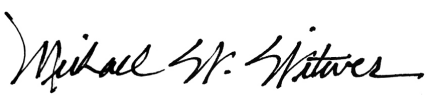
For purposes of the Campus Violence Benefit***, Campus*** means any building or property owned or controlled by an institution within the same reasonably contiguous geographic area and used by the institution in direct support of, or in a manner related to, the institution's educational purposes. This also includes residence halls. It also includes any building or property owned or controlled by a student organization that is officially recognized by the institution; or any building or property owned or controlled by an institution that is used in direct support of, or in relation to, the institution's educational purposes; is frequently used by students, and is not within the same reasonably contiguous geographic area of the institution. Examples include:

a. research facilities;
b. university-owned hospitals;
c. off-campus student housing facility owned by a third party that has a written contract with the institution to provide student housing;
d. student residential facility owned or controlled by the institution;
e. a publicly owned athletic stadium that is leased by the institution for its athletic events or other institution functions.

The additional amount payable is as follows:

Loss of Life = 25% of Principal Sum to maximum of $50,000

Nothing contained in this Rider shall be held to alter or affect any provision or condition of your coverage other than as stated above.



President

# 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**
1717 West 6th Street, Suite 230
Austin, Texas 78703-4776
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

**Texas Department of Insurance**
P.O. Box 12030
Austin, Texas 78711
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). **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.

GEN-76-0223

# Cómo estar protegido si su compañía de seguro de vida o de salud falla

La Asociación de Garantía de Seguros de Vida y Salud de Texas lo protege pagando sus reclamos cubiertos si su compañía de seguro de vida o salud es insolvente (no puede pagar sus deudas). **Este aviso resume sus protecciones**.

La Asociación pagará sus reclamos, con algunas excepciones requeridas por la ley, si su compañía de seguros tiene licencia en Texas y un tribunal la ha declarado insolvente. Debe vivir en Texas cuando su compañía de seguros falla. Si no vive en Texas, aún puede tener algunas protecciones.

## Por cada compañía insolvente, la Asociación pagará los reclamos de una persona solo hasta estos límites en dólares establecidos por ley:

- **Seguros de accidentes, accidentes y salud, o salud (incluidos los HMO):**
  - Hasta $500,000 para planes de beneficios de salud, con algunas excepciones.
  - Hasta $300,000 para beneficios de ingresos por discapacidad.
  - Hasta $300,000 para beneficios de seguro de cuidado a largo plazo.
  - Hasta $200,000 para todos los demás tipos de seguro de salud.
- **Seguro de vida:**
  - Hasta $100,000 en valor neto de rescate o retiro de efectivo.
  - Hasta $300,000 en beneficios por muerte.
- **Anualidades individuales:** hasta $250,000 en el valor presente de los beneficios, incluidos los valores de rescate en efectivo y retiro neto de efectivo.
- **Otros tipos de pólizas:** los límites para pólizas grupales, planes de jubilación y anualidades de liquidación estructurada se encuentran en el Capítulo 463 del Código de Seguros de Texas.
- **Límite agregado individual:** hasta $300,000 por persona, independientemente de la cantidad de pólizas o contratos. Se puede aplicar un límite de $500,000 para personas con planes de beneficios de salud.
- **Es posible que partes de algunas pólizas no estén protegidas:** por ejemplo, no hay protección para partes de una póliza o contrato que la compañía de seguros no garantiza, como algunas adiciones al valor de las pólizas de vida o anualidades variables.

Para obtener más información sobre la Asociación y sus protecciones, comuníquese con:

**Texas Life and Health Insurance Guaranty Association**
1717 West 6th Street, Suite 230
Austin, TX 78703-4776
1-800-982-6362 www.txlifega.org

Para preguntas sobre seguros comuníquese con:

**Texas Department of Insurance**
P.O. Box 12030
Austin, Texas 78711
1-800-252-3439 or www.tdi.texas.gov

**Nota**: usted recibió este aviso porque la ley de Texas requiere que su compañía de seguros le envíe un resumen de sus protecciones bajo la Ley de Asociación de Garantía de Seguro de Vida y Salud de Texas (Código de Seguro, Capítulo 463). **Puede haber otras excepciones que no están incluidas en este aviso**. Al elegir una compañía de seguros, no debe confiar en la cobertura de la Asociación. La ley de Texas prohíbe a las compañías y agentes utilizar la Asociación como incentivo para comprar cobertura de seguro o HMO.

El Capítulo 463 controla si hay diferencias entre la ley y este resumen.

GEN-76-0223 SP

**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: Contract Specialist 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 with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

**¿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: Contract Specialist 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 con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

# 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 an 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 FOR LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS:**

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).**

**Insurance Plans**

We will give You a decision no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received.

If the claim is denied, 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;
- 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.

Any denied claim may be appealed to the Insurer by You or Your authorized representative, at the address specified in the claim denial, for a full and fair review. The review will be conducted by a person different from the person who made the initial decision and the reviewer will not review the merits of the claim with the original examiner nor be the original examiner's subordinate. The claimant may:

a) request a review upon written application within 60 days of receipt of claim denial;

b) upon request and free of charge, review pertinent documents, records and other information relevant to the claim and receive copies of same; and

c) submit issues, comments, records, and other information in writing.

A decision will be made by the Insurer no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. We will notify You in writing if an extension is needed. If We need information from You and You deliver that information within the time specified, the extension will begin after You provide the information. If You do not provide the information in that time period, We may decide Your appeal without that information. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision will advise You of any other appeal rights You have under the Plan, as well as Your right to bring an action under Section 502(a) of ERISA, 29 U.S.C. §1132(a).

**C. CLAIMS PROCEDURE FOR WAIVER OF PREMIUM BENEFITS:**

When You are eligible to receive benefits, 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).**

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 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 receipt of claim denial;

b) upon request and free of charge, review pertinent documents, records and other information relevant to the claim and receive copies of same; and

c) submit issues, comments, records, and other information in writing.

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**