



**BlueCross BlueShield
of Texas**

Group Long Term Disability Insurance

Employee Benefit Booklet

Uplift Education

VF028267-0001

Class 1-01

Dearborn Life Insurance Company

Group Certificate

Dearborn Life Insurance Company

Chicago, Illinois

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

Having issued Group Policy No. VF028267-0001

(herein called the *Policy* or this Plan)

to

Uplift Education

(herein called the *Policyholder*)

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

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

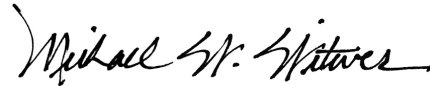
If the terms and provisions of the Certificate of Coverage (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy*.

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company



Secretary



President

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

Group Long Term Disability Certificate

Non-Participating

THIS IS NOT A WORKERS' COMPENSATION CERTIFICATE

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

SCHEDULE OF BENEFITS

| | | |
|--|---|--|
| Policyholder: | Uplift Education | |
| Policy Number: | VF028267-0001 | |
| Effective Date: | September 1, 2023 | |
| Eligibility: | The following are eligible: 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. | |
| Class #01 | <p>A full-time <i>Employee</i> is one who regularly works a minimum of 30 hours per week for the <i>Policyholder</i>. Part-time, seasonal and temporary <i>Employees</i> of the <i>Policyholder</i> are not eligible.</p> | |
| Waiting Period: | <p>If <i>You</i> are in a class eligible for insurance on or before the Policy Effective Date: None</p> <p>If <i>You</i> enter a class eligible for insurance after the Policy Effective Date: First of the month following Date of Hire of continuous, full-time Active Work</p> | |
| Elimination Period: | 180 Days | |
| Elimination Period: Catastrophic Disability Benefit | 180 Days | |
| LTD Monthly Benefit: | 50% of <i>Monthly Earnings</i> to a maximum <i>Gross Monthly Benefit</i> of \$7,500 per month subject to reduction by deductible sources of income or <i>Disability Earnings</i> | |
| Social Security Offset Method: | Primary & Family | |
| Minimum Monthly Benefit: | \$100 or 10% of <i>Your Gross LTD Monthly Benefit</i> , whichever is greater | |
| Policyholder Contribution: | 100% of premium | |
| Employee Contribution: | 0% of premium | |
| Maximum Period Payable: | Age on Date Disability Commences | Maximum Period Payable |
| | Less than 60 | To SSNRA* |
| | 60 | 60 months or to SSNRA*, whichever is greater |
| | 61 | 48 months or to SSNRA*, whichever is greater |
| | 62 | 42 months or to SSNRA*, whichever is greater |

| | |
|------------|---|
| 63 | 36 months or to SSNRA*, whichever is greater |
| 64 | 30 months or to SSNRA*, whichever is greater |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 or over | 12 months |

* Social Security Normal Retirement Ages Based on the 1983 amendment to the Social Security Act, the following are normal retirement ages by date of birth.

| Year of Birth | Social Security Normal Retirement Age |
|----------------------|--|
| 1937 or earlier | 65 years |
| 1938 | 65 years, 2 months |
| 1939 | 65 years, 4 months |
| 1940 | 65 years, 6 months |
| 1941 | 65 years, 8 months |
| 1942 | 65 years, 10 months |
| 1943-1954 | 66 years |
| 1955 | 66 years, 2 months |
| 1956 | 66 years, 4 months |
| 1957 | 66 years, 6 months |
| 1958 | 66 years, 8 months |
| 1959 | 66 years, 10 months |
| 1960 or later | 67 years |

Catastrophic Disability Benefit:

To the End of the *Maximum Period Payable*

OTHER FEATURES

The following other features are included:

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

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

ELIGIBILITY AND EFFECTIVE DATES

Who is eligible for this insurance?

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

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

00001

When does Your Noncontributory insurance become effective?

If *You* are an eligible *Employee*, *Your Noncontributory* coverage under the Policy will become effective on the day following completion of the *Waiting Period*, if any, shown 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. If, because of *Injury* or *Sickness*, *You* are not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work*.

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

00002

Change in Family Status means a change in status as defined in the regulations under Internal Revenue Code section 125, unless *Your Employer's* cafeteria plan document or human resource policy contains more restrictive provisions. In that event, *Your Employer* may restrict the situations where you can change your coverage.

00004-B

Changes to Your coverage

A change in *Your* coverage may occur if:

1. *You* enroll for a different coverage option; or
2. There is a Policy change.

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

Additional coverage for reasons other than a Policy change will be effective the first of the month following the later of:

1. The date *You* enroll for the additional coverage;
2. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

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

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

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

00006

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

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

00007

Who pays for Your coverage?

The *Policyholder* pays the entire cost of *Your* coverage.
00008

Do You have to pay premium while You receive benefits?

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

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

Effect on Actively at Work requirement

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

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

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

Effect on Benefits

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

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

The *Prior Policy* is the group disability insurance policy issued to the *Policyholder* by Lincoln Financial whose coverage terminated immediately prior to the Policy Effective Date.

Effect on Pre-existing Conditions

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

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

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

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

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

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

1. *Your Monthly Benefit* will be the lesser of:
 - a. The *Monthly Benefit* that would have been payable under the terms of the *Prior Policy* if it had remained in force; or
 - b. The *Monthly Benefit* under this Plan.
2. Benefits will end on the earlier of:

- a. The date benefits end under the Policy, as described under the *Maximum Period Payable*; or
- b. The date benefits would have ended under the *Prior Policy* if it had remained in force.

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

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

00010-A

Eligibility after Your Coverage Ends

If *Your* coverage ends due to termination of employment or because *You* cease to be a member of a class eligible for this insurance, *You* must meet all the requirements of a new *Employee* if *You* are rehired or resume work as a member of a class eligible for this insurance at a later date.

00109

LONG TERM DISABILITY BENEFITS

How do We define Total Disability?

Total Disability or **Totally Disabled** means that during the first 24 consecutive months of benefit payments due to *Sickness* or *Injury*;

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

00011-A

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

1. You are continuously unable to engage in any *Gainful Occupation*, and
2. Your *Disability Earnings*, if any, are less than 20% of Your pre-disability *Indexed Monthly Earnings*.

00013-A

How do We define Partial Disability?

Partial Disability or **Partially Disabled** means that:

1. During the *Elimination Period* You are unable to perform all of the *Material and Substantial Duties* of Your Regular Occupation.
2. During the first 24 consecutive months of benefit payments, due to *Injury* or *Sickness* You are unable to perform one or more of the *Material and Substantial Duties* of Your Regular Occupation, and Your *Disability Earnings*, if any, are at least 20% but less than or equal to 80% of Your pre-disability *Indexed Monthly Earnings*.
3. After the LTD Monthly Benefit has been paid for 24 consecutive months **Partial Disability** or **Partially Disabled** means that due to *Injury* or *Sickness*, You are unable to engage in any *Gainful Occupation*; and Your *Disability Earnings*, if any, are at least 20% but less than or equal to 60% of Your pre-disability *Indexed Monthly Earnings*.

00014-A

Loss of Professional License or Certification

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

00017

What is the Elimination Period and how is it satisfied?

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

If You temporarily recover and return to work, We will treat Your *Disability* as continuous if You return to work for a period of less than or equal to one-half the *Elimination Period* rounded up to the next whole number, not to exceed 90 days. The days that You are not *Disabled* will not count toward Your *Elimination Period*.

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

00018-A

Can You satisfy Your Elimination Period if You are working?

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

00019

What Disability Benefit are You eligible to receive?

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

1. an LTD Monthly Benefit;
2. a Work Incentive Benefit; or
3. Rehabilitation Incentive Income.

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

00020

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

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

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

1. Multiply *Your Monthly Earnings* by 50%.
2. The maximum *Gross LTD Monthly Benefit* is \$7,500.00.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit*.
4. Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.
5. Compare the answer from item 3 and 4.

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

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

00021-C

How do We define Monthly Earnings?

Monthly Earnings means *Your* gross monthly income from *Your Employer* in effect on the July 1 just prior to *Your Date of Disability*. 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. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than *Your Employer*.

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the *Monthly Benefit*.

00022

What are the Deductible Sources of Income?

1. *Disability* benefits paid, payable, or for which *You* are eligible under:
 - a. The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;
 - b. Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
 - c. Occupational accident coverage provided by or through the *Policyholder*;
 - d. Any Statutory Disability Benefit Law;
 - e. The Railroad Retirement Act;
 - f. The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
 - g. The Canada Old Age Security Act;
 - h. Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans;
 - i. Title 46, United States Code Section 688 et seq (The Jones Act);
 - j. Title 33, United States Code Section 901 et seq (Longshore and Harbor Workers' Compensation Act).
2. *Disability* benefits paid, payable, or for which *You* are eligible under:
 - a. Any group insurance plan provided by or through the *Policyholder*, and
 - b. Any sick leave, paid time off or salary continuance plan provided by or through the *Policyholder* which causes the *Net Monthly Benefit*, plus Deductible Sources of Income and any salary continuation to exceed 100% of

Your pre-disability Indexed Monthly Earnings. The amount in excess of 100% of *Your pre-disability Indexed Monthly Earnings* will be used to reduce *Your Net Monthly Benefit*.

- c. Any federal, state, or local paid family medical leave or similar plan.
3. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;
4. Retirement and *Disability* benefits paid under a Retirement Plan provided by the *Policyholder* except for amounts attributable to *Your* contributions;
5. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;
6. Amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the net settlement.
7. Any unemployment benefits *You* are eligible to receive.

Proration of Lump Sum Awards

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

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

What other sources of income are not deductible?

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

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2. credit disability insurance;
3. pension plans for partners;
4. military pension and disability income plans;
5. franchise disability income plans;
6. individual disability income plans;
7. a *Retirement Plan* from another *Policyholder*;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

00023-A

Can You work and still receive benefits?

While *Disabled*, *You* may qualify for the Work Incentive Benefit or Rehabilitation Incentive Income, but not both.

Work Incentive Benefit

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

The Work Incentive Benefit will be calculated during the first 12 months of disability payments while *You* are *Gainfully Employed* as follows:

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

After the first 12 months of disability payments while *You* are *Disabled* and *Gainfully Employed*, the Work Incentive Benefit will be equal to the *Net Monthly Benefit* multiplied by the *Adjusted Loss of Salary Ratio*.

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

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

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

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

B= Your pre-disability *Indexed Monthly Earnings*

Rehabilitation Incentive Income

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

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

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

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

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

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

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

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

B= Your pre-disability *Indexed Monthly Earnings*

00024-A

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

The *Net LTD Monthly Benefit* payable for *Disability* will not be less than \$100 or 10% of *Your Gross LTD Monthly Benefit*, whichever is greater. The minimum *Net LTD Monthly Benefit* does not apply if *You* are *Gainfully Employed*.

00025

What happens if Your Deductible Sources of Income increase?

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

00026

How long will You receive benefits under the Policy?

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

00027

What happens if Your Disability recurs?

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

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

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

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

00028

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

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

- a *Pre-existing Condition*;
- commission of, participation in, or an attempt to commit an assault or felony;
- intentionally self-inflicted injuries;
- attempted suicide, regardless of mental capacity;
- participation in a war, declared or undeclared, or any act of war;
- active military duty;
- commission of a crime for which *You* have been convicted;
- active *Participation in a Riot*.

The Policy has limitations on:

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

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

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

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

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

Furthermore:

- Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
- Benefits are not payable during the first 24 months of *LTD Monthly Benefits*, when *You* are able to return to work in *Your Regular Occupation* on a part-time basis but *You* do not.
- Benefits are not payable after 24 months of *LTD Monthly Benefits*, when *You* are able to work in any *Gainful Occupation* on a part-time basis but *You* do not.

00029-A

TERMINATION OF COVERAGE

When will Your insurance terminate?

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

1. the date on which the Policy is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the date on which the *Employer's* participation under the Policy is terminated; or
4. the date *You*:
 - a. are no longer a member of a class eligible for this insurance,
 - b. request termination of coverage under the Policy,
 - c. are retired or pensioned, or
 - d. cease work because of a *Leave of Absence, Furlough, Layoff, Sabbatical*, military leave, or temporary work stoppage due to a *Labor Dispute*. However, *You* may continue to be eligible for group insurance coverage, as follows:

Leave of Absence: Until the end of the month following the month during which the Leave of Absence began, provided all premiums are paid when due, the Policy is in force, and *Your* coverage is not replaced with group disability insurance.

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

00030-A

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 or local family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the FMLA; or
2. the leave period permitted by applicable state or local law.

While granted a FMLA or State FML leave:

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*.

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

00031-A

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

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

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

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

00032-A

SUPPLEMENTAL BENEFITS AND SERVICES

FAMILY CARE EXPENSE BENEFIT

Are Family Care Expense Benefits available while You are Disabled?

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

Family Care Expenses mean monthly expenses, up to \$350 per *Eligible Family Member* per month, to a maximum total benefit of \$1,000.00 per month, charged by a licensed care provider who is not a member of *Your* immediate family or living in *Your* residence.

Eligible Family Member means *Your Dependent Child* under age 13 who lives with *You*; or

Any of the following family members who lives with *You* and is unable to perform, without human assistance or regular supervision from another person, at least 2 of the 6 *Activities of Daily Living*; or is *Cognitively Impaired*:

- *Your Spouse*
- *Your* parent, grandparent, or *Dependent Child* of any age
- *Your Spouse's* parent, grandparent, or *Dependent Child* of any age

Dependent Child(ren) means any unmarried child of *Yours*, whether natural, step, foster or adopted, who is primarily dependent on *You* for financial support and maintenance.

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

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

00034-B

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

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

1. After the Disability had continued for 6 or more consecutive months; and
2. While receiving an LTD Monthly Benefit.

The Survivor Income Benefit shall be payable on a lump sum basis immediately after *We* receive written proof of *Your* death. The benefit will be equal to 3 times *Your Last Monthly Benefit*. The benefit shall accrue from *Your* date of death.

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

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

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

Last Monthly Benefit means the *Monthly Benefit* paid to *You* immediately prior to *Your* death, but not including any reductions for Deductible Sources of Income.

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

00036

CATASTROPHIC DISABILITY BENEFIT

What is a Catastrophic Disability Benefit?

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

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

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

When will Your coverage become effective?

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

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

How much will We pay if You are Disabled?

The Catastrophic Disability Benefit is 10% of pre-disability *Indexed Monthly Earnings* to a maximum Catastrophic Disability Benefit of the lesser of the maximum *LTD Monthly Benefit* or \$5,000.

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

When will Your Catastrophic Disability Benefit payments end?

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

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

What claim information is needed for Catastrophic Disability Benefits?

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

CAREGIVER RESPITE BENEFIT

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

1. *You* must be receiving a Catastrophic Disability Benefit;
2. The benefit is payable if Informal Home Care has been provided for at least 6 continuous months for *You* beginning with *Your Date of Disability*;
3. The benefit is payable for Companion Care received by *You* in *Your* home or a private residence during a Respite Interval;
4. The benefit is equal to the daily Companion Care cost incurred, not to exceed \$100 per day; and
5. The benefit is payable to *You* following submission of proof of *Your* incurred costs for Companion Care during the Respite Interval.

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

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

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

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

CAREGIVER TRAINING BENEFIT

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

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

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

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

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

EMERGENCY ALERT SYSTEM BENEFIT

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

1. *You* must be receiving a Catastrophic Disability Benefit;
2. The benefit is payable for a medically necessary *Emergency Alert System*;
3. *Your* condition must be such that *You* could not be left alone were it not for the presence of the *Emergency Alert System*;
4. The benefit is the lesser of \$25 per month or the actual cost to rent or lease the *Emergency Alert System*;
5. The benefit is payable to *You*, in arrears, after every 6 months, following submission of proof of *Your* incurred costs for the *Emergency Alert System*; and
6. We will not pay for any charges incurred as a result of installing, servicing or maintaining the *Emergency Alert System*. This includes, but is not limited to, any charges for normal telephone service while the system is installed or for a home security system.

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

00042

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

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

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

1. \$5,000; or
2. 2 times *Your Last Monthly Benefit*.

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

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

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

Additionally, We may assist *You* and an *Employer*, other than the *Policyholder*, in identifying modifications We agree are likely to help *You* return to work. This agreement will be in writing and must be signed by *You*, the *Employer* making the modification and *Us*.

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

1. \$5,000; or
2. 2 times *Your Last Monthly Benefit*.

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

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

00044-A

RELOCATION EXPENSE BENEFIT

What is the Relocation Expense Benefit?

If *You* are receiving a *Monthly Benefit* under the Policy at the end of the *Maximum Period Payable* and participate in a *Rehabilitation Plan*, *You* may be eligible to receive a Relocation Expense Benefit.

We will pay a Relocation Expense Benefit to *You* if all the following conditions are met:

1. *You* are receiving a *Monthly Benefit*;
2. *You* participate in a *Rehabilitation Plan*;
3. *You* cannot return to *Gainful Employment* for an employer, or on a self-employment basis within a 50 mile radius of your residence;
4. *You* can return to *Gainful Employment* for an employer, or on a self-employment basis more than a 50 mile radius from *Your* residence; and
5. *You* obtain approval by *Us*, in writing, for the *Relocation Expense*.

Relocation Expense means an expense *You* incur in the process of relocating *Your* primary residence to facilitate *Your* return to *Gainful Employment* limited to the following:

1. Temporary living expense;

2. Expenses associate with *Your* home search;
3. Relocation travel expenses;
4. Closing costs, transfer taxes, real estate agent commissions or attorney fees for home purchase and sale;
5. Shipment of household goods; or
6. Release from a lease payment on *Your* current primary residence.

The Relocation Expense Benefit pays the amount of the *Relocation Expense*, for which *You* supply satisfactory proof to *Us*, that *You* incurred such expenses up to the lesser of:

1. \$5000; or
2. 3 times *Your Monthly Benefit*.

We will not reimburse *You* for any expense that is incurred for services provided by a member of *Your* immediate family or someone who is living in *Your* residence.

The Relocation Expense Benefit is not subject to the *Maximum Gross Monthly Benefit*.

00111 Rev 091621

CLAIM SERVICES

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

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

Vocational Rehabilitation Service

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

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

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

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

Social Security Disability Assistance

When necessary, *We* will provide an advocate for *You* in applying for and securing Social Security *Disability* awards. When *We* determine that Social Security Assistance is appropriate for *You*, it is provided at no additional cost to *You*.
00047

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Written Proof of Loss

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

Time Limit for Filing Your Claim

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

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

1. It was not reasonably possible to give written proof during the 1 year period, and

2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of Disability

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

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

Continuing Proof of Disability

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

Examination

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

Authorization and Documentation You will be asked to supply

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

00048 TX

Time of Payment of Claim

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

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

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

00049-A

Can You assign Your benefits?

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

What will happen if a claim is overpaid?

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

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

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

Subrogation Right of Reimbursement

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

00050

UNIFORM PROVISIONS

Entire Contract; Changes

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

Legal Actions

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

1. until 60 days after proof of claim has been given; or
2. more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

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

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective.

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

1. Use the facts to decide whether *You* have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Misstatement of Age

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

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

Incontestability

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

Conformity with State Statutes and Regulations

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

Workers' Compensation or State Disability Insurance

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

Agency

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

General Provisions

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

1. 2 years after termination of the Policy; or
2. all claims under the Policy have been settled, whichever is later.

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

00051 TX

DEFINITIONS

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

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

00052

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

1. working for the *Policyholder* on a full-time active basis; or
2. working at least the minimum number of hours shown in the *Schedule of Benefits*: and either:
 - a. working at the *Policyholder's* usual place of business; or
 - b. working at a location to which the *Policyholder's* business requires *You* to travel;
3. a legal citizen or resident of the United States of America;
4. are paid regular earnings by the *Policyholder*, and
5. not 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).

00053

Activities of Daily Living means:

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

00054

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

00055

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

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

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

00056

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

00057

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

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes any earnings *You* could receive if *You* were working to *Your Maximum Capacity*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.

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

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

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

Employee means an *Actively at Work* 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 at least the number of hours per week as stated in the *Application* and is reported on the *Policyholder's* records for Social Security and withholding tax purposes.
00069

Furlough means *You* are temporarily not *Actively at Work*, due to the reduction or suspension of work hours, at written the instruction of *Your* Employer for a specified length of time. *Furlough* does not include permanent reduction or suspension of work hours, indefinite reduction or suspension of work hours, or termination of employment.
00104

Gainful Occupation, Gainful Employment or **Gainfully Employed** means the performance of any occupation within the national economy, for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, and in which you earn, or could be reasonably expected to earn, 60% or more of *Your* pre-disability *Indexed Monthly Earnings*.
00063

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

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

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

Indexed Monthly Earnings means *Your Monthly Earnings* adjusted on each anniversary of benefit payment by the lesser of 7% or the current annual percentage increase in the Consumer Price Index. *Your Indexed Monthly Earnings* may increase or remain the same, but will never decrease.

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

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

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

Labor Dispute means *You* are temporarily not *Actively at Work*, due to a work stoppage, slowdown, strike, lockout or similar work disruption, over terms of employment.
00105

Layoff means *You* are temporarily not *Actively at Work*, due to suspension of work hours, at written the instruction of *Your Employer*. *Layoff* does not include permanent suspension of work hours, or termination of employment.
00106

Leave of Absence means *You* are temporarily not *Actively at Work*, for a period of time, that *Your Employer* has agreed to in writing. *Leave of Absence* does not include permanent reduction or suspension of work hours, indefinite reduction or suspension of work hours, or termination of employment.
00107

LTD means Long Term Disability.
00070

Male pronoun, whenever used, includes the female.
00071

Material and Substantial Duties means duties that:

1. are normally required for the performance of *Your Regular Occupation*; and
 2. cannot be reasonably omitted or modified, except that if *You* are required to work on average in excess of 40 hours per week, *We* will consider *You* able to perform that requirement if *You* have the capacity to work 40 hours.
- 00072

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

1. During the first 24 consecutive months of *Monthly Benefit* payments, the greatest extent of work *You* are able to do in *Your Regular Occupation*; and
 2. Beyond 24 consecutive months of *Monthly Benefit* payments, the greatest extent of work *You* are able to do in any *Gainful Occupation*.
- 00073

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

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

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

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

Monthly Earnings means *Your* gross monthly income from *Your Employer* in effect on the July 1 just prior to *Your Date of Disability*. 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. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than *Your Employer*.
00078

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

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

00080

Pre-existing Condition means a condition which:

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

00081

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

00082

Rehabilitation Plan means a written agreement between *You* and *Us*. Its purpose is to assist *You* in returning to *Gainful Employment*. The *Rehabilitation Plan* will outline the time and dates of the vocational rehabilitation services, *Our* responsibilities, *Your* responsibilities and the responsibilities of any third party which might be involved. The *Rehabilitation Plan* will be at *Our* expense, at the expense of the third party, or a shared expense of *Ours* and a third party. At *Our* discretion, the *Rehabilitation Plan* will include the Day Care Expense Benefit.

00083

Retirement Plan means a plan which provides retirement benefits to *Employees* and is not funded wholly by *Employee* contributions.

00084

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

00085

Sabbatical means *You* are temporarily not *Actively at Work*, to engage in other work-related activities or study, which has been agreed upon in advance in writing by *Your* Employer. *Sabbatical* does not include termination of employment.

00108

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

00086

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

00087-A

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

00091

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

00092

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

00093

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

00094

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

00095

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.

Disability Resource Services

What is Disability Resource Services?

Disability Resource Services is a noninsurance benefit made available to **You** which provides access at no additional cost to the following services:

- Access to Guidance Resources® Online, a secure, password-protected interactive website that contains self-assessments, search tools, extensive content on personal health, relational, legal, health and financial concerns for *You*.
- Access to unlimited telephonic counseling service. This service provides access to experts to provide *You* with assessment, counseling and referral advice.
- Up to three face-to-face counseling sessions.

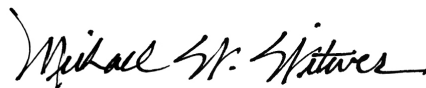
How Do You Access Disability Resource Services?

Guidance Resources is accessed online. *Your* employer will provide *You* with a password to use on the website. The website URL is www.GuidanceResources.com. Telephonic and face to face counseling is available if you qualify as stated above. To contact a counselor, please call 1-866-899-1363.

Guidance Resources and telephonic counseling is provided by ComPsych® Corporation. We do not underwrite or administer this program.

When do Disability Resource Services Terminate?

- Disability Resource Services terminate if *Your* coverage is terminated under the section on *When does Your coverage under the Policy end?* located in the Termination Provision of the contract; or,
- When you are no longer qualify for Total Disability or Partial Disability benefits under 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 Insured under

the Group Long Term Disability Insurance Policy

Provided by Dearborn Life Insurance Company

Regarding the Disability Resource Services Noninsurance Benefit

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

Noninsurance Benefit Description and How the Benefit May Be Obtained

Disability Resource Services is a noninsurance benefit that provides you with a link to Guidance Resources® Online, a secure, password-protected interactive website that contains self-assessments, search tools, and extensive content on personal health, relational, legal, health and financial concerns for insured persons and their family.

In addition *You* have access to telephonic counseling by calling 1-866-899-1363, and up to three face-to-face counseling sessions.

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 and provided by ComPsych® Corporation.

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

Why This Service is Being Made Available

We are making this service available to provide support and assistance to insureds who have suffered a loss that is covered by the group disability insurance policy. Living with a disability can be difficult, and this program provides counseling, and assistance with locating services to support the insured and their family members.

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 Disability Resource Services noninsurance benefit is available following a covered loss for as long as you remain covered under the group disability insurance policy and such policy remains in effect.

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

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:

For questions about insurance, contact:

Texas Life and Health Insurance Guaranty Association **Texas Department of Insurance**

1717 West 6th Street, Suite 230

P.O. Box 12030

Austin, Texas 78703-4776

Austin, Texas 78711

1-800-982-6362 or www.txlifega.org

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:

Para preguntas sobre seguros 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

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.

END OF CERTIFICATE

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148