BlueCross BlueShield of Illinois

Group Long Term Disability Insurance

Employee Benefit Booklet

The Thresholds

VF027745-0001

Class 1-02

12/02/2022

This plan is an "employee welfare benefit plan," ("Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document serves to provide important information about the Plan. It is not the entire Plan document, but a summary of important information about the Plan. In addition to this summary plan description ("SPD"), ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. Your employer or Plan Administrator maintains the full Plan Document. If there is a conflict between the Plan Document and this SPD, the Plan Document controls. A copy of the Plan Document is available for review during normal working hours in the office of the Plan Administrator.

The benefits described in your Plan document are provided under a group Plan sponsored by the Employer and insured by Blue Cross and Blue Shield of Illinois.

SUMMARY PLAN DESCRIPTION	
1. PLAN NAME: If different, the name by which the plan is commonly known.	Employee Welfare Plan
2. PLAN TYPE:	Welfare Benefit Plan providing a Group Long Term Disability Policy and Certificate
3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS: Name and address of employer sponsoring the Plan or employee organization maintaining the Plan	The Thresholds 4101 North Ravenswood Ave Chicago, IL 60613
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	36-2518901
5. PLAN NUMBER: Number assigned by the Plan Sponsor. This number is used for Form 5500 reporting. Each Plan should be assigned a unique number that is not used more than once.	501
6. ERISA PLAN YEAR ENDS ON EACH: This is the end of the Plan Year for maintaining the Plan's fiscal records and may be different from the insurance policy year.	12/31
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	The Thresholds 4101 North Ravenswood Ave Chicago, IL 60613 (773) 572-5400
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	
9. SOURCES OF FUNDING AND CONTRIBUTIONS: Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.	The Plan is funded as an insured plan under policy number VF027745 issued by Blue Cross and Blue Shield of Illinois. Contributions to the Plan are made as stated on the Schedule of Benefits in the Group Insurance Certificate. The employer determines the method of funding and contributions, if any, to be made by the participants.

10. TYPE OF ADMINISTRATION:	This plan is administrated by insurer administration.
11. CLAIM ADMINISTRATION:	The Claim Administrator is not the "plan administrator" of your Plan, as defined in Section 3(16)(A) of ERISA. The Plan Administrator has selected Blue Cross and Blue Shield of Illinois as the claims administrator of your Plan and has delegated to Blue Cross and Blue Shield of Illinois the authority and discretion to administer the terms of the applicable group policy provisions such as making initial claim determinations concerning the availability of benefits, and the final review and benefit determinations for appealed claims.
12. EACH TRUSTEE'S NAME, TITLE, AND ADDRESS OF PRINCIPAL PLACE OF BUSINESS: This is only applicable if the Plan has trustees.	
13. LABOR ORGANIZATION: This is applicable if the Plan is subject to a CBA.	
14. PLAN AMENDMENT AND TERMINATION PROCEDURE:	The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan (including any related documents and underlying policies), in whole or in part, at any time, without prior notice. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures. Rights with respect to termination of insurance benefits are stated in the Policy and Certificate. The employer can request a Policy change, including a change to benefits, rights and obligations under the Policy but only an officer of Blue Cross and Blue Shield of Illinois can approve a change to the Policy. The change must be in writing and endorsed on or attached to the Policy
15. ELIGIBILITY FOR PARTICIPATION AND BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
16. CIRCUMSTANCES CONCERNING INELIGIBILITY, DISQUALIFICATION, OR DENIAL OR LOSS OF BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
17. CLAIMS PROCEDURES: The procedures which govern claims for benefits and requests for review of denied claims.	The Plan's claims procedures are furnished automatically, without charge, as a separate document. Refer to the ERISA Information Statement incorporated herein by reference.

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. VF027745-0001

(herein called the Policy or this Plan)

to

The Thresholds

(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

Group Long Term Disability Certificate

Non-Participating

THIS IS NOT A WORKERS' COMPENSATION CERTIFICATE

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PROVISION

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

SCHEDULE OF BENEFITS

Policyholder:	The Thresholds
Policy Number:	VF027745-0001
Effective Date:	January 1, 2023
Eligibility: **Class #02**	The following are eligible: All Other 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 20 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.
Waiting Period:	If *You* are in a class eligible for insurance on or before the Policy Effective Date: Immediately following 90 Days of continuous, full-time Active Work If *You* enter a class eligible for insurance after the Policy Effective Date: Immediately following 90 Days of continuous, full-time Active Work
Elimination Period:	90 Days
LTD Monthly Benefit:	60% of *Monthly Earnings* to a maximum *Gross Monthly Benefit* of $7,500 per month subject to reduction by deductible sources of income or *Disability Earnings*
Social Security Offset Method:	Primary & Family
Minimum Monthly Benefit:	$100 or 10% of *Your Gross LTD Monthly Benefit*, 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 Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months

65	24 months
66	21 months
67	18 months
68	15 months
69 or over	12 months

OTHER FEATURES

The following other features are included:

- Waiver of Premium
- Work Incentive Benefit
- Rehabilitation Incentive Income
- Recurrent Disability
- FMLA Coverage Extension
- Conversion Privilege
- Survivor Benefit
- Family Care Expense Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- 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 s*atisfactory 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 Life Insurance Company of North America 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.

Exception: If *Your* coverage ends due to termination of employment and you return to A*ctive Work* in an eligible class within 30 days, we will not:

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

Exception: If *Your* coverage ends because *You* cease to be a member of a class eligible for this insurance, without termination of employment, and you return to *Active Work* in an eligible class within 6 months, we will not:

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

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 L*TD 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 60%.
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 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 Y*our 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 24 months of disability payments while *You* are *Gainfully Employed* as follows:

1. The *Gross Monthly Benefit* amount and *Disability Earnings* amount will be added together and compared 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 amount 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 24 months of disability payments while *You* are *Disabled* and *Gainfully Employed*, the Work Incentive Benefit will be equal to the *Net Monthly Benefit* amount reduced by 50% of *Disability Earnings*.

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*.

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 24 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 24 months of *Gainful Employment*, Rehabilitation Incentive Income will be equal to the *Net LTD Monthly Benefit* reduced by 50% of Disability Earnings.

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*.

00024-B

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 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;
- active *Participation in a Riot*;
- commission of a crime for which *You* have been convicted;

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-IL 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 i*nsurance 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* or *Domestic Partner*
- *Your* parent, grandparent, or *Dependent Child* of any age
- *Your Spouse's* or *Domestic Partner'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 24 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

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

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

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

1. $1,500; 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. $1,500; 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

CONVERSION PRIVILEGE

What are Your conversion options if You end employment?

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

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

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

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

1. *You* are or become insured under another group long term disability plan within 31 days after *Your* employment ends;
2. *You* are *Disabled* under the terms of the Policy;
3. *You* recover from a *Disability* and do not return to work for the *Policyholder;*
4. *You* are on a *Leave of Absence*; or
5. *Your* coverage under the Policy ends for any of the following reasons:
   a. the Policy is canceled;
   b. the Policy is changed to exclude the class of Employees to which *You* belong;

c. *You* are no longer in an eligible class;

d. *You* end *Your* working career or retire and receive payment form the *Policyholder's* Retirement Plan; or

e. *You* fail to pay the required premium under the Policy.

00046

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 Assistanc*e**

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 90 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 90 days, the claim is not affected if the proof is given as soon as possible. How*e*ver, 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. How*e*ver, *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. 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

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit within 30 days, so long as *You* continue to qualify for it. If any claim is paid after the 30th day, it will be paid at 9% per annum from the 30th day.

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-IL 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 bet*we*en the parties. Coverage under the Policy can be amended by mutual consent betwe*e*n 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 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 *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

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 an unexpected event that was not reasonably foreseeable.
00052-IL

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

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

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

Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to *You,* similar to that of a *Spouse,* as evidenced by the following:

1. *You* and *Your Domestic Partner* share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. *You* and *Your Domestic Partner* each are at least eighteen (18) years of age;
3. *You* and *Your Domestic Partner* are both mentally competent to enter into a binding contract;
4. *You* and *Your Domestic Partner* share a residence and have done so for at least 12 months;
5. Neither *You* nor *Your Domestic Partner* are married to or legally separated from anyone else;
6. *You* and *Your Domestic Partner* are not related to one another by blood closer than would bar marriage; and

Neither *You* nor *Your Domestic Partner* is a *Domestic Partner* of anyone else.

Where the laws of the governing jurisdiction mandate a definition of *Domestic Partner* other than shown above, that definition will be used in the Policy.
00060

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 independent of disease or bodily infirmity. 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 - IL

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 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 recognized in the general workplace and according to industry standards, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location. *We* may use the Dictionary of Occupational Titles published by the Department of Labor and any other appropriate resource in making our determination.

00082 - IL

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. *Spouse will include Your Domestic Partner.*

00091

Substance Use Disorder 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 - IL

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

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

DEARBORN LIFE INSURANCE COMPANY

Chicago, Illinois

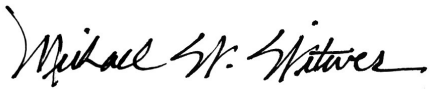
AMENDATORY ENDORSEMENT

This Amendatory Endorsement amends the Policy or Certificate to which it is attached. It takes effect and ends at the same time as the Policy or Certificate to which it is attached. All provisions of the Policy or Certificate will apply to this Amendatory Endorsement, except that in the event of a conflict, the specific provisions of this Amendatory Endorsement will govern.

The term **Spouse**, wherever it appears in the Policy or Certificate, is amended as follows:

Spouse includes a **Party to a Civil Union.**

In addition to civil unions entered into under Illinois law, the term **Civil Union** includes a marriage between persons of the same sex, a civil union, a domestic partnership, or a substantially similar legal relationship, other than common law marriage, legally entered into in another jurisdiction.



President

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

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ('the Association') and the protection it provides for policyholders. This safety net was created under Illinois law which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
  - $300,000 for death benefits
  - $100,000 for cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefits plan*
  - $300,000 for disability insurance benefits
  - $300,000 for long-term care insurance benefits
  - $100,000 for other types of health insurance benefits
- Annuities
  - $250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health *Insurance Guaranty Association* *901 Warrenville Road, Suite 400* *Lisle, Illinois 60532-4324*	*Illinois Department of Insurance* *4th Floor* *320 West Washington Street* *Springfield, Illinois 62767*

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

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

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

1. Receive Information about Your Plan and Benefits
   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

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

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

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

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

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

A. ADMINISTRATION OF THE PLAN

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

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

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

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

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

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

B. CLAIMS PROCEDURE :

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

Claims Department

Blue Cross and Blue Shield of Illinois

701 E. 22nd Street

Lombard, IL. 60148

1-800-367-6401

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

Disability Insurance Plans

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

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

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

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

You may:

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

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

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

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

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

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

Administrative Office:

701 E. 22nd Street

Lombard Illinois 60148

Principal Office:

300 E. Randolph Street

Chicago Illinois 60601