BlueCross BlueShield of Illinois

Group Short Term Disability Insurance

Employee Benefit Booklet

Winning Wheels, Inc.

VF028774-0001

Class 1-02

12/04/2023

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 Short 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	Winning Wheels, Inc. 501 6th Avenue West Lyndon, IL 61261
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	237136038
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.	December 31
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	Winning Wheels, Inc. 501 6th Avenue West Lyndon, IL 61261 815-778-3683
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	Winning Wheels, Inc. 501 6th Avenue West Lyndon, IL 61261
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 VF028774 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

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

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

Having issued Group Policy No. VF028774-0001

(herein called the *Policy*)

to

Winning Wheels, Inc.

(herein called the *Policyholder*)

Group Insurance Certificate

CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, become insured and remain insured in accordance with the terms of the *Policy. Your* insurance is subject to all the definitions, limitations and conditions of the *Policy.* 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 Short Term Disability Insurance Certificate

Non-Participating

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SCHEDULE OF BENEFITS

Policyholder:	Winning Wheels, Inc.
Policy Number:	VF028774-0001
Effective Date:	January 1, 2024
Eligibility: **Class 02**	All Active Full Time Non-Administrators working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.
Eligibility Waiting Period:	**Current Employees** If *You* are in a class eligible for insurance on or before the *Policy* Effective Date: None **New Employees** If *You* enter a class eligible for insurance after the *Policy* Effective Date: First of the month following 0 Days of continuous, full-time Active work
Short Term Disability	
STD Benefit Percentage	60% of *Your Weekly Earnings*, not to exceed $500.00
Maximum STD Weekly Benefit	$500.00
Minimum STD Weekly Benefit	$25.00
Elimination Period	14 Days - *Injury* 14 Days - *Sickness*
Benefits are Payable on	Day 15 of *Injury* Day 15 of *Sickness*
Maximum Period Payable	11 Weeks following the *Elimination Period* or until benefits become payable under the Long Term Disability plan, whichever occurs first
Benefits are Payable for	Non-occupational disabilities only
Policyholder Contribution	100% of Premium

OTHER FEATURES

- Work Incentive Benefit
- Recurrent Disability
- Worksite Modification
- Survivor Benefit
- FMLA Coverage Extension

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 DATE PROVISIONS

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 later of the *Policy* effective date or the first of the month that falls on or next follows 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 E*vidence 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.

Noncontributory means the *Policyholder* pays 100% of the premium for this insurance.
00002

When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after the date *You* are eligible for insurance; or
2. *You* voluntarily canceled *Your* insurance and are reapplying; or
3. *You* apply for coverage amounts in excess of the Guarantee Issue Benefit Limit as shown in the *Schedule of Benefits*.

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.

You may obtain an *Evidence of Insurability Form* from the *Policyholder.*
00006

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

If *You* are absent from *Active Work* on the date *Your* coverage would otherwise become effective; and *Your* absence is caused by an *Injury*, illness or layoff, *Your* effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work*. However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

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

00008

Changes to Your coverage

A change in *Your* coverage may occur if:

1. There is a *Policy* change; or
2. *You* enter another class and become eligible for a change in benefits.

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

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

Any decrease in coverage will take effect immediately.
00009

Who pays for Your coverage?

The *Policyholder* pays the entire cost of *Your* coverage.
00010

What happens if We are replacing an existing Policy?

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 paid 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* whose coverage terminated immediately prior to the *Policy* Effective Date.

We will require proof that *You* were insured under the *Prior Policy*.
00012

Eligibility after You Terminate Employment

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

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

1. apply a new *Eligibility Waiting Period*;
2. require *Evidence of Insurability*.

00013

SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or ***Disabled*** means that *You* satisfy the definition of either *Total Disability* or *Partial Disability* and *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor.*

Unless periods of *Disability* are separated by *Your* return to *Active Work* for at least 14 consecutive days, successive periods of *Disability* resulting from injuries received in any one *Accident* or from any one *Sickness* or related *Sicknesses* will be considered one period of *Disability.*
00014

How do We define Total Disability?

Total Disability or ***Totally Disabled*** means that due to *Sickness* or *Injury You* are continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation,* and *Your Disability Earnings*, if any, are less than 20% of *Your* pre-disability *Weekly Earnings*.
00015

How do We define Partial Disability?

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

1. During the *Elimination Period You* are able to perform some but not all of the *Material and Substantial Duties* of *Your Regular Occupation*; and
2. After the *Elimination Period*, due to *Injury* or *Sickness, You* are able to perform some but not all 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 *Weekly Earnings*.

You will no longer be considered *Partially Disabled* when *You* are able to increase *Your* current earnings by increasing the number of hours *You* work or the number of duties *You* perform in *Your Regular Occupation* but *You* do not do so.
00017

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.*
00019

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 14 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 14 days, whichever is less, and become *Disabled* again, *You* will have to begin a new *Elimination Period.*
00020

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.*
00021

What Disability Benefit are You eligible to receive?

If *You* are *Disabled* and receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor, You* are eligible to receive one of the following at any given time:

1. an *STD Weekly Benefit*; or
2. a Work Incentive Benefit.

While *You* are *Disabled, You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
00022

What is Your STD Weekly Benefit and how is it calculated?

Your STD Weekly Benefit will be based on *Your Weekly Earnings* as reported to *Us* by *Your Employer* and for which premium has been paid.

An *STD Weekly Benefit* will be payable after the end of the *Elimination Period* if *You* are *Disabled.*

We will calculate *Your Gross STD Weekly Benefit* amount as follows:

1. Multiply *Your Weekly Earnings* by the STD Benefit Percentage, shown on the *Schedule of Benefits*.
2. The maximum *STD Weekly Benefit* as shown on the *Schedule of Benefits*.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross STD Weekly Benefit*.
4. Subtract the Deductible Sources of Income from *Your Gross STD Weekly Benefit.* The resulting figure is *Your Net STD Weekly Benefit*.

If a benefit is payable for less than one week, *STD Weekly Benefit* payments will be made at a daily rate of 1/7th the weekly benefit.
00023-A

Can You work and still receive benefits?

While *Partially Disabled, You* may qualify for the Work Incentive Benefit.
00025

What is the Work Incentive Benefit and how is it calculated?

We will pay a Work Incentive Benefit if *You* are *Partially Disabled* and *Gainfully Employed* after the end of the *Elimination Period*, or after a period during which *You* received *STD Weekly Benefits*.

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 *STD Weekly Benefits.*

The Work Incentive Benefit will be calculated while *You* are *Gainfully Employed* as follows:

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

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

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

The payment of a Work Incentive Benefit, combined with *Your STD Weekly Benefit,* will not extend the *Maximum Period Payable,* as shown on the *Schedule of Benefits*.
00026

What are the Deductible Sources of Income?

The *Gross STD Weekly Benefit* under the *Policy* will be reduced by:

1. *Disability* benefits paid, payable or for which *You* are eligible under:
    a. any state compulsory disability benefit *Act* or *Law*.
    b. any group insurance plan provided by or through the *Policyholder.*
    c. any State Teachers Retirement System, Public Employees Retirement System or School Employees Retirement System.

d. the Social Security *Act*, including any amounts for which *Your* dependents may qualify because of *Your Disability*.

e. the Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act.

f. the Canada Old Age Security *Act*.

g. any Workers' Compensation or Occupational Disease *Act* or *Law*, or any other *Law* which provides compensation for an occupational *Injury* or *Sickness.*

Denial of Workers' Compensation will not result in the payment of benefits under the *Policy* if *Your Disability* resulted from an occupational *Sickness* or *Injury*. Benefits are also not payable under the *Policy* if *You* are entitled to participate in Workers' Compensation and choose not to do so.

2. Any *Accumulated Sick Leave* or *Salary Continuation* plan provided by or through the *Policyholder* which causes the *Net STD Weekly Benefit*, plus Deductible Sources of Income and any *Salary Continuation* to exceed 100% of *Your* pre-disability *Weekly Earnings*. The amount in excess of 100% of *Your* pre-disability *Weekly Earnings* will be used to reduce *Your Net Weekly Benefit.*
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.

Act or ***Law*** means the original enactment of the *Law* or *Act* and all amendments.

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 STD Weekly Benefit* as follows:

1. *We* will divide the amount paid by the number of weeks for which the settlement or advance was provided; or
2. If the number of weeks 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 weeks for which *We* will provide benefits for *Your Disability* based on the Proof of *Disability* which *We* have, subject to a maximum of 26 weeks.

What other sources of income are not deductible?

We will not reduce *Your Gross STD Weekly Benefit* under the *Policy* 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 Employer;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

00028

What is the minimum Net STD Weekly Benefit payable under the Policy?

The *Net STD Weekly Benefit* payable for *Disability* will not be less than $25.00. The minimum *Net STD Weekly Benefit* does not apply if *You* are *Gainfully Employed*.
00029

What happens if Your Deductible Sources of Income increase?

The *Net STD Weekly 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.
00030

How long will You receive benefits under the Policy?

We will send *You* a payment for each week 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*.
00031

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 14 days 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 14 days 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*.
00032

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 to, directly, by any one or more of the following:

1. loss of professional license, occupational license or certification;
2. commission of, participation in, or an attempt to commit an assault or felony;
3. Intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. *Cosmetic Surgery* except when required due to *Injury* or *Sickness*;
6. Occupational *Injury* or *Sickness*;
7. participation in a war, declared or undeclared, or any act of war.

Furthermore:

1. Benefits are not payable if *Your Disability Earnings* exceed 80% of *Your* pre-disability*Weekly Earnings*.
2. Benefits are not payable if *You* are able to return to work in *Your Regular Occupation* on a part-time basis but *You* do not.
3. 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.

00033 IL

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 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, or temporary work stoppage due to a labor dispute, unless We and the Policyholder have agreed in writing in advance of the leave to continue insurance during such period.

Termination will not affect Your claim for a covered loss which began while the coverage was in force.
00034

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

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

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

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

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

While granted a Family or Medical Leave of Absence:

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

If the *Policyholder's* Human Resource policy does not provide for continuation of *an Employee's* Short Term Disability coverage during a family and medical leave of absence, the *Employee's* coverage will be reinstated when he or she returns to active employment.

We will not:

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

00035

SUPPLEMENTAL BENEFITS

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

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

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

1. $1,500.00; or
2. 2 times *Your Last STD Weekly 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 the *Policyholder* have been provided to *Us;* and
3. *You* have returned to work and are an *Actively at Work Employee*.

For the purposes of this provision, *Last STD Weekly Benefit* means the weekly 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.
00038

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 You had received *STD Weekly Benefits* for 3 or more consecutive weeks; and
2. While receiving an *STD Weekly Benefit.*

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

Eligible Survivor means *Your Spouse*, if living, or if *Your Spouse* dies before the 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, in equal payments; 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.

For the purposes of this provision, *Last STD Weekly Benefit* means the weekly 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.
00039

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.

Telephonic Claim Notification

In lieu of written Proof of Claim, *We* may accept telephonic notice and Proof. All time limits in the *Policy* applicable to the filing of Proof of Disability and commencement of Legal Actions shall apply to notice and proof filed by telephone or other means acceptable to *Us.*

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. 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 Weekly 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.

00040

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, as 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 beneficiaries: *Your*: 1) *Spouse*; 2) children including legally adopted children; 3) parents; or 4) *Your* estate.

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

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 Weekly 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 *STD Weekly Benefits* are suspended while recovery of the overpayment is being made, suspension will also apply to the minimum *STD Weekly Benefits* payable under the *Policy.*

00041 IL

Right of Reimbursement

If a covered person recovers expenses for *Sickness* or *Injury* that occurred due to the negligence of a third party, *We* have the right to first reimbursement for all benefits *We* paid from any and all damages collected from the negligent

third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents, if the covered person is a minor, or the covered person's legal representative as a result of that *Sickness* or *Injury. You* are required to furnish any information or assistance, or provide any documents that *We* may reasonably require in order to exercise *Our* rights under this provision. This provision applies whether or not the third party admits liability.
00042 A IL

Subrogation

We are assigned the right to recover from the negligent third party, or his or her insurer, to the extent of the benefits *We* paid for that *Sickness* or *Injury. You* are required to furnish any information or assistance, or provide any documents that *We* may reasonably require in order to exercise *Our* rights under this provision. This provision applies whether or not the third party admits liability.
00042 B IL

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 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.

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.

00043

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 to these definitions.

Accident or ***Accidental*** means, an unexpected event that was not reasonably foreseeable.
00044 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); and
7. *You* were not *Hospital Confined* or *Disabled* due to an *Injury* or *Sickness.*

00045

Accumulated Sick Leave or ***Salary Continuation*** means continued payments to *You* by *Your Employer* of all or part of your *Weekly Earnings* after *You* become *Disabled* as defined by the *Policy.* This continued payment must be part of an established plan maintained by Y*our Employer* for the benefit of all *Employees* covered under the *Policy. Accumulated Sick Leave or Salary Continuation* does not include compensation paid to *You* by *Your Employer* for work *You* actually perform after *Your Disability* begins. Such compensation is considered *Disability Earnings.*
00046

Act or ***Law*** means the original enactment of the *Law* or *Act* and all amendments.
00047

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.
00049

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.
00050

Cosmetic Surgery means any procedure which is directed at improving a person's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
00053

Date of Disability means the date *We* determine that *You* are *Disabled.*
00054

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

If *Your Disability Earnings* routinely fluctuate widely from week to week, *We* may average *Your Disability Earnings* over the most recent three weeks 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 weeks exceeds 80% of *Your Weekly Earnings.*
00055

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.
00056

Domestic Partner means an adult of the same or opposite gender who has executed a D*omestic Partner* affidavit, or 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
7. 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.*
00057

Eligible Survivor means *Your Spouse*, if living, or if *Your Spouse* dies before the benefit is paid, then *Your* children who are under age 23.
00058

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.*
00059

Employee means an *Actively at Work* full-time *Employee* whose principal employment is with the *Employer*, at the *Employer's* usual place of business or such place(s) that the *Employer's* normal course of business may require, who is *Actively at Work* for the minimum hours per week as stated in the *Application* and is reported on the *Employer's* records for Social Security and withholding tax purposes.
00060

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.
00061

Evidence of Insurability Form means a form provided or approved by *Us* on which *You* provide a statement of *Your* medical history.
00062

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

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

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

Hospital means either of the following:

1. A licensed *Hospital* which
    a. maintains on the premises all facilities necessary for major surgical treatment,

b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed physicians, and

c. provides 24-hour service by registered graduate nurses.

2. A free-standing surgical facility which maintains on the premises all facilities necessary for major surgical treatment available to the hospital on a prearranged basis.

The term *Hospital* does not include an institution which is primarily a place for rest or convalescence, a place for the aged, a nursing home, a place for the treatment of alcohol or drug abuse or any facility primarily affording custodial, educational, or rehabilitative care.
00066 IL

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.*
00067 IL

Last STD Weekly Benefit, for the Worksite Modification Benefit, means the weekly 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.
00068

Last STD Weekly Benefit, for the Survivor Benefit, means the weekly benefit paid to *You* immediately prior to *Your* death, but not including any reductions for Deductible Sources of Income.
00069

Male pronoun, whenever used, includes the female.
00070

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.

00071

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.
00072

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.*
00073

Net STD Weekly Benefit means the *Gross STD Weekly Benefit* less the Deductible Sources of Income.
00075

Noncontributory means *Your Employer* pays 100% of the premium for this insurance.
00076

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy. If the Policyholder is a trust, the term Participating Employer shall be substituted for Policyholder.
00078

Prior Policy means the group disability insurance policy issued to the *Policyholder* whose coverage terminated immediately prior to the *Policy* Effective Date.
00080

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.
00081 IL

Schedule of Benefits means the schedule which is a part of this certificate.
00082

Sickness means *Sickness* or disease causing *Disability* which begins while *You* are covered under the *Policy.*
00083

Spouse means lawful *Spouse. Spouse* will include *Your Domestic Partner.*
00084a

STD means Short Term Disability.
00085

STD Weekly Benefit means the *STD Weekly Benefit* shown in the *Schedule of Benefits* which applies to *You.*
00086

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*.
00087

Weekly Earnings means *Your* gross weekly 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 includes income actually received from bonuses for the calendar year just prior to *Your Date of Disability*, but does not include commissions, overtime pay, or any other extra compensation, or income received from sources other than *Your Employer*.

Bonuses will be averaged for the lesser of:

a. the 12 full calendar month period of *Your* employment with *Your Employer* just prior to the date *Disability* begins; or

b. the period of actual employment with *Your Employer*.

00088

We, Our and ***Us*** mean the Dearborn Life Insurance Company, Chicago, Illinois.
00089

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.*
00090

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

DEARBORN LIFE INSURANCE COMPANY

Chicago, Illinois

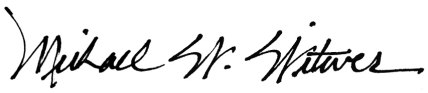
AMENDATORY ENDORSEMENT

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