Voluntary Short Term Disability Insurance

Employee Benefit Booklet

THE UNIVERSITY OF TEXAS SYSTEM
GFZ71778-0001
Class 1-01
Dearborn Life Insurance Company

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

Having issued Group Policy No. GFZ71778-0001

(herein called the Policy)

to

The University of Texas System

(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

[Signatures]

Secretary

President

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

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Group Voluntary Short-Term Disability Insurance Certificate

Participating

DL2-610-UT-0621
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SCHEDULE OF BENEFITS

Policyholder: The University of Texas System
Policy Number: GFZ71778-0001
Effective Date: September 1, 2009 (Revised September 1, 2021)

Annual Enrollment Period: 7/15 to 7/31

Eligibility: All active benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment.

Class 01

Eligibility Waiting Period: The date of hire or the first day of the month following the date of hire, whichever you elect when you enroll.

Short-Term Disability

STD Benefit 60% of Your Weekly Earnings to a maximum of $850 per week subject to reduction by deductible sources of income or Disability Earnings.

Elimination Period 7 Days - Injury
7 Days – Sickness

Elimination Period is extended to the later of the period shown above or the expiration of Your Sick Leave.

Benefits are Payable on Day 8 of Injury
Day 8 of Sickness

Maximum Period Payable 22 weeks following the Elimination Period or until benefits become payable under the Long Term Disability plan, whichever occurs first.

For Disability caused by a Pre-Existing Condition: Up to 4 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 0% of Premium

OTHER FEATURES

• Work Incentive Benefit
• Recurrent Disability
• 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?**

All active benefit eligible employees who are Actively at Work for the Policyholder who are expected to work at least 20 hours per week and to continue in the employment for a term of at least 4½ months or appointed for at least 50% of a standard full-time appointment are eligible.

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

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

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

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

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

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

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

**Change in Family Status**

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

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

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

7. You return to work after a leave of absence.

What happens if You take a leave of absence?

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

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

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

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

If You do not return to work on the first work day following the date Your leave of absence ends, Your coverage will terminate on the date Your leave of absence ended.

If You terminate Your coverage when Your leave of absence begins or before the end of the approved leave of absence period, You must re-enroll when You return to work after a leave of absence. Evidence of Insurability is required if You do not re-enroll within 31 days of returning to work after a leave of absence.

When is Evidence of Insurability required?

Evidence of Insurability is required if:

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

2. You voluntarily canceled Your insurance and are reapplying.

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.

What is an Annual Enrollment period?

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

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

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

**Who pays for Your coverage?**

You pay the entire cost of *Your* coverage.

**What happens if We are replacing an existing policy?**

Benefits are payable for a *Disability* caused by, contributed to, or resulting from a *Pre-existing Condition*. The *Gross STD Weekly Benefit* is equal to 60% of *Your Weekly Earnings* up to a maximum *Gross STD Weekly Benefit* of $850 and reduced by the Deductible Sources of Income or *Disability Earnings*. The benefit is payable for up to 4 weeks.

**Eligibility after You Terminate Employment**

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

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

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

How do We define Total Disability?

If the institutions are in session, 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.

If the institutions are not in session, Total Disability or Totally Disabled means that due to Sickness or Injury You would be continuously unable to perform the Material and Substantial Duties of Your Regular Occupation, and Your Disability Earnings, if any, would be less than 20% of Your pre-disability Weekly Earnings.

How do We define Partial Disability?

If the institutions are in session, Partial Disability or Partially Disabled means that:

1. During the Elimination Period You are able to perform some but not all of the Material & 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.

If the institutions are not in session, Partial Disability or Partially Disabled means that:

1. During the Elimination Period You would be unable to perform some but not all of the Material & Substantial Duties of Your Regular Occupation; and
2. After the Elimination Period, due to Injury or Sickness, You would be able to perform some but not all of the Material and Substantial Duties of Your Regular Occupation; and Your Disability Earnings, if any, would be 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.

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.

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 7 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 7 days and become Disabled again, You will have to begin a new Elimination Period.

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.

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.

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 60%.
2. The maximum STD Weekly Benefit is $850.
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.

Can You work and still receive benefits?
While Partially Disabled, You may qualify for the Work Incentive Benefit.

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

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What are the Deductible Sources of Income?

The Gross STD Weekly Benefit under the Policy will be reduced by Disability benefits paid under any State Teachers Retirement System, Public Employees Retirement System or School Employees Retirement System.

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.

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.

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.

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.
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 or indirectly, by any one or more of the following:

1. a Pre-Existing Condition, except as provided under the “What happens if We are replacing an existing policy?” section;
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. Occupational Injury or Sickness;
6. 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.
TERMINATION OF COVERAGE

When will Your insurance terminate?

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

1. the date on which the Policy is terminated;
2. the date at the end of the period for which premium has been paid if the Employer fails to pay the required premium for You within 90 days after the premium due date, except for an inadvertent error; or
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 (see Extension of Coverage below), furlough, layoff, or temporary work stoppage due to a labor dispute, unless We and the Policyholder have agreed in writing in advance of the leave to continue insurance during such period. Orders to active military service for 2 months or less will be covered subject to continued payment of premium.

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

Extension of Coverage

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

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

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.
FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Written Proof of Loss

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

Time Limit for Filing Your Claim

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

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

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

Proof of Disability

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

1. The date Your Disability began;
2. The cause of Your Disability;
3. The prognosis of Your Disability;
4. Proof that You are receiving Appropriate and Regular Care for Your condition from a Doctor, who is someone other than You or a member of Your immediate family, whose specialty or expertise is the most appropriate for Your disabling condition(s) according to Generally Accepted Medical Practice.
5. Objective medical findings which support Your Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for Your disabling condition(s).
6. The extent of Your Disability, including restrictions and limitations which are preventing You from performing Your Regular Occupation.
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.

Time of Payment of Claim

As soon as We have all necessary substantiating documentation for Your Disability claim, We will pay Your benefit at least as frequently as once every two weeks, as long as You continue to qualify for it.

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

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

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.

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**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.

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UNIFORM PROVISIONS

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

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

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

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

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

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

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

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

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

Misstatement of Age
If Your age has been misstated, an equitable adjustment will be made in the premium.

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.

**Premium Provisions**

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

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

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

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**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 a sudden, unexpected event that was not reasonably foreseeable.

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

1. working for the *Policyholder* on an active basis; or
2. working at least the minimum number of hours shown in the Schedule of Benefits: and either:
   a. working at the *Policyholder*’s usual place of business; or
   b. working at a location to which the *Policyholder*’s business requires *You* to travel;
3. are paid regular earnings by the *Policyholder*.

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

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

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave); and
You were not Hospital Confined or disabled due to an Injury or Sickness.

**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 your 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.

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

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

**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.

**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.

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

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

**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 20% of Your Weekly Earnings.

**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.

**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.

**Employee** means an Actively at Work 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.

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

**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.

**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.

**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.

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

**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.

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.

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

**Male pronoun**, whenever used, includes the female.

**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.
**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.

**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*.

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

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

**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.

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

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

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

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

**STD** means Short-Term Disability.

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

**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*.

**Weekly Earnings** will equal the greater of:

1. 1/52nd of *Your* last reported gross annual income from *Your* *Employer* in effect on the day immediately prior to *Your* Date of Disability.
2. 1/52nd of *Your* gross annual income from *Your* *Employer* in effect on September 1 immediately prior to *Your* Date of Disability.

It includes:

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

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

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

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

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

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

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

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

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

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

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

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

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

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

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

For questions about insurance, contact:

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

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

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714
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.
The benefits described in your certificate are insured by a Disability Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Texas ("We" or "Insurer"), pursuant to an "employee welfare benefit plan" ("the Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1), established by your employer, or where applicable, employee organization (the "Policyholder").

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

**A. ADMINISTRATION OF THE PLAN**

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

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

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

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

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

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

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

Claims Department
Blue Cross and Blue Shield of Texas
701 E. 22nd Street
Lombard, IL 60148
1-877-442-4207

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

Disability Insurance Plans

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

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

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

You may:
- request a review upon written application within 180 days of the claim denial;
- request, free of charge, copies of all documents, records and other information relevant to your claim; and
- 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