Voluntary Long Term Disability Insurance

Employee Benefit Booklet

QUEST GLOBAL, INC.

F013731-0001

Class 1-02

02.11.2014

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 Dearborn National Life Insurance Company.

SUMMARY PLAN DESCRIPTION	
1. PLAN NAME: If different, the name by which the plan is commonly known.	EMPLOYEE WELFARE PLAN
2. PLAN TYPE:	Welfare Benefit Plan providing a Group Long Term Disability Policy and Certificate
3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS: Name and address of employer sponsoring the Plan or employee organization maintaining the Plan	QUEST GLOBAL, INC. 123 RIVERSIDE DR CARTERSVILLE, GA 30120
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	58-2538378
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.	11/30
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	QUEST GLOBAL, INC. 123 RIVERSIDE DR CARTERSVILLE, GA 30120 678-455-9323
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	
9. SOURCES OF FUNDING AND CONTRIBUTIONS: Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.	The Plan is funded as an insured plan under policy number F013731 issued by Dearborn National Life Insurance Company. 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 Dearborn National Life Insurance Company ("Dearborn National") as the claims administrator of your Plan and has delegated to Dearborn National 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 Dearborn National Life Insurance Company 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 National® Life Insurance Company

Group Certificate

Dearborn National Life Insurance Company

Chicago, Illinois

Administrative Office: 1020 31st Street • Downers Grove, IL 60515

Having issued Group Policy No. **F013731-0001**

(herein called the Policy or this Plan)

to

QUEST GLOBAL, INC.

(herein called the Policyholder)

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

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

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

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn National Life Insurance Company

William R Barnes
Secretary

President

Group Voluntary Long Term Disability Certificate

Non-Participating

THIS IS NOT A WORKERS' COMPENSATION CERTIFICATE

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

SCHEDULE OF BENEFITS

Policyholder:	QUEST GLOBAL, INC.
Policy Number:	F013731-0001
Effective Date:	December 1, 2013 - Revised
Eligibility:	The following are eligible: All Other active full-time Excluding Truck Drivers 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.
Waiting Period:	If *You* are in a class eligible for insurance on or before the Policy Effective Date: The day following completion of 90 Days of continuous, full-time active work If *You* enter a class eligible for insurance after the Policy Effective Date: The day following completion of 90 Days of continuous, full-time active work
Elimination Period:	180 Days
Rates Per $100 of Monthly Benefit:	**Age** / **Rate** Below 20 — $0.123 20 to 24 — $0.123 25 to 29 — $0.165 30 to 34 — $0.178 35 to 39 — $0.206 40 to 44 — $0.329 45 to 49 — $0.617 50 to 54 — $0.930 55 to 59 — $1.276 60 to 64 — $1.523 65 to 69 — $1.523 70 to 74 — $1.523 75 to 79 — $1.523 80 to 84 — $1.523 85 and above — $1.523
LTD Monthly Benefit:	As selected by *You*, from a minimum of $500.00 per month to a maximum of $5,000.00 per month subject to reduction by deductible sources of income or *Disability Earnings*, in increments of $100. The amount selected cannot exceed 60% of *Your* monthly salary.

Social Security Offset Method:	Primary & Family	
Minimum Monthly Benefit:	$100.00	
Policyholder Contribution:	0% of premium	
Maximum Period Payable:	**Age on Date *Disability* Commences**	**Maximum Period Payable**
	Less than 60	To SSNRA*
	60	60 months or to SSNRA*, whichever is greater
	61	48 months or to SSNRA*, whichever is greater
	62	42 months or to SSNRA*, whichever is greater
	63	36 months or to SSNRA*, whichever is greater
	64	30 months or to SSNRA*, whichever is greater
	65	24 months
	66	21 months
	67	18 months
	68	15 months
	69 or over	12 months

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

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

OTHER FEATURES

The following other features are included:

- Waiver of Premium
- Work Incentive Benefit
- Rehabilitation Incentive Income
- Recurrent Disability
- FMLA Coverage Extension
- Survivor Benefit
- Rehabilitation Benefit
- Day Care Benefit
- Worksite Modification Benefit
- Vocational Rehabilitation Service
- Social Security Assistance
- Continuity of Coverage

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

ELIGIBILITY AND EFFECTIVE DATES

Who is eligible for this insurance?

The following people are eligible: All Other active full-time Excluding Truck Drivers

The *Waiting Period* is shown in the *Schedule of Benefits.*
00001

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* after the end of the *Waiting Period*, but within 31 days after that day, *Your* coverage will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*.
3. If *You* sign the *Enrollment Form* following this 31-day period, *You* are considered a late applicant and must furnish *Evidence Of Insurability satisfactory to Us* before coverage can become effective. Coverage will become effective on the date *We* determine that the *Evidence of Insurability* is satisfactory and *We* provide written notice of approval.

You must be *Actively at Work* for coverage under the Policy to become effective. If, because of *Injury* or *Sickness*, *You* are not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day *You* return to *Active Work.*

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.
00003

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 to increase *Your* coverage amount during an annual enrollment period; or *You* apply to increase *Your* coverage amount during the Policy year.

You may obtain an *Evidence of Insurability Form* from *the Policyholder*.
00005

Changes to Your coverage

A change in *Your* coverage may occur if:

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

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

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

1. The date *You* enroll for the additional coverage;

2. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

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

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

Any decrease in coverage will take effect immediately. If the *Date* of *Disability* was prior to the decrease, any claim resulting from that *Disability* will be paid at the amount in effect at the time the Disability was incurred.
00006

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

Evidence of Insurability Form means a form provided or approved by Us on which you provide a statement of *Your* medical history.
00007

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.
00008

Do You have to pay premium while You receive benefits?

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

What happens if We are replacing an existing Policy?

Effect on Actively at Work requirement

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

1. The end of the month following the date *You* become *Actively at Work*;

2. The end of any period of continuance or extension provided under the *Prior Policy*; or

3. The date coverage would otherwise end, according to the provisions of the Policy.

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

Effect on Benefits

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

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

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

Effect on Pre-existing Conditions

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

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

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

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

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

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

1. *Your Monthly Benefit* will be the lesser of:
    a. The *Monthly Benefit* that would have been payable under the terms of the *Prior Policy* if it had remained in force; or
    b. The *Monthly Benefit* under this Plan.
2. Benefits will end on the earlier of:
    a. The date benefits end under the Policy, as described under the Maximum Period Payable; or
    b. The date benefits would have ended under the *Prior Policy* if it had remained in force.

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

We will require proof that *You* were insured under the *Prior Policy*.
00010

LONG TERM DISABILITY BENEFITS

How do We define Total Disability?

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

1. *You* are continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation,* or

2. *Your Disability Earnings,* if any, are less than 20% of *Your* pre-disability *Indexed Monthly Earnings*.

00011

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

1. *You* are continuously unable to engage in any *Gainful Occupation,* or

2. *Your Disability Earnings,* if any, are less than 20% of *Your* pre-disability *Indexed Monthly Earnings*.

00013

How do We define Partial Disability?

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

1. During the *Elimination Period You* are unable to perform all of the *Material* and *Substantial Duties* of *Your Regular Occupation*.

2. During the first 24 consecutive months of benefit payments, due to *Injury* or *Sickness You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation,* or *Your Disability Earnings,* if any, are at least 20% but less than or equal to 80% of *Your* pre-disability *Indexed Monthly Earnings*.

3. After the *LTD Monthly Benefit* has been paid for 24 consecutive months *Partial Disability* or *Partially Disabled* means that due to *Injury* or *Sickness, You* are unable to engage in any *Gainful Occupation;* or *Your Disability Earnings*, if any, are at least 20% but less than or equal to 60% of *Your* pre-disability *Indexed Monthly Earnings*.

00014

Loss of Professional License or Certification

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

00017

What is the Elimination Period and how is it satisfied?

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

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

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

00018

Can You satisfy Your Elimination Period if You are working?

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

00019

What Disability Benefit are You eligible to receive?

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

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

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
00020

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

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

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

1. Take the amount *You* have selected at enrollment not to exceed 60% of *Monthly Earnings*
2. The maximum *Gross LTD Monthly Benefit* is $5,000.00.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit.*
4. Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.

If a benefit is payable for less than one month, it will be paid on the basis of $1/30^{th}$ of the *Net LTD Monthly Benefit* for each day of *Disability*.
00021-B

Earnings, whether for a full year or partial year, will be converted to a monthly amount for the purpose of calculating the *Monthly Benefit*.
00022

What are the Deductible Sources of Income?

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

2. *Disability* benefits paid, payable, or for which You are eligible under:

    a. Any group insurance plan provided by or through the Policyholder , and

    b. Any sick leave or salary continuance plan provided by or through the Policyholder which causes the *Net Monthly Benefit*, plus Deductible Sources of Income and any salary continuation to exceed 100% of *Your* pre-disability *Indexed Monthly Earnings*. The amount in excess of 100% of *Your* pre-disability *Indexed Monthly Earnings* will be used to reduce *Your Net Monthly Benefit*.

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. Retirement and *Disability* retirement benefits paid under any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans;

6. *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.

Proration of Lump Sum Awards

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

1. *We* will divide the amount paid by the number of months for which the settlement or advance was provided; or

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

What other sources of income are not deductible?

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

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;

2. credit disability insurance;

3. pension plans for partners;

4. military pension and disability income plans;

5. franchise disability income plans;

6. individual disability income plans;

7. a *Retirement Plan* from another *Policyholder*;

8. profit sharing plans;

9. thrift or savings plans;

10. individual retirement account (IRA);

11. tax sheltered annuity (TSA);

12. stock ownership plan.

00023

Can You work and still receive benefits?

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

Work Incentive Benefit

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

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

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

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

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

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

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

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

B= *Your pre-disability Indexed Monthly Earnings*

Rehabilitation Incentive Income

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

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

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

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

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

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

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

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

B= *Your* pre-disability *Indexed Monthly Earnings*

00024-A

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

The *Net LTD Monthly Benefit* payable for *Disability* will not be less than $100.00. The minimum Net LTD Monthly Benefit does not apply if You are Gainfully Employed
00025

What happens if Your Deductible Sources of Income increase?

The *Net LTD Monthly Benefit* will not be further reduced for subsequent cost-of-living increases which are paid, payable, or for which *You* or *Your* dependents are eligible under any Deductible Source of Income shown above.
00026

How long will You receive benefits under the Policy?

We will send *You* a payment for each month of *Disability* up to the *Maximum Period Payable* as shown in the *Schedule of Benefits.* Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.
00027

What happens if Your Disability recurs?

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

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

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

Disability must recur while *Your* coverage is in force under the Policy.
00028

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

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

- *a Pre-Existing Condition*;
- commission of, participation in, or an attempt to commit an assault or felony;
- Intentionally self-inflicted injuries;
- attempted suicide, regardless of mental capacity;
- participation in a war, declared or undeclared, or any act of war;
- active military duty;
- active *Participation in a Riot*;

The *Policy* has limitations on:

- *Mental Disorder - Disability* beyond 12 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 12-month limit.
- *Substance Abuse* – A *Substance Abuse* (drug or alcohol) related *Disability* unless *You* are participating in a *Substance Abuse* treatment program approved by the State where the treatment program is provided. The cost of the treatment program must be borne by *You* or another group plan of the *Policyholder* (such as a group health plan or Employee Assistance Program) if one is available and covers this type of treatment.

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

1. 12 *LTD Monthly Benefit* payments have been made; or
2. the *Maximum Period Payable* is reached; or
3. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
4. *You* are no longer following the requirements of *Your* treatment plan under the program; or
5. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

- *Special Conditions - Disability* beyond 12 months after the *Elimination Period* if it is due to a *Special Conditions* related *Disability*. Confinement in a *Hospital* or institution licensed to provide care and treatment of *Special Conditions* will not count toward the 12 month limit.

The lifetime cumulative *Maximum Period Payable* for all disabilities due to a *Mental Disorder*, *Substance Abuse*, and *Special Conditions* is 12 months. Only 12 months of benefits will be paid for any combination of such disabilities even if the disabilities:

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

Furthermore:

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

00029

TERMINATION OF COVERAGE

When will Your insurance terminate?

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

1. the date on which the Policy is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the date on which the Employer's participation under the Policy is terminated; or
4. the date *You*:
    a. are no longer a member of a class eligible for this insurance,
    b. request termination of coverage under the Policy in writing,
    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 a covered loss which began while the coverage was in force.
00030-GA

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, *You*r 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.

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 *You*r agreement with the *Policyholder*.

00031

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

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

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

00032

Will coverage be continued for other leaves of absence?

If *You* are on an approved leave of absence other than an FMLA or State FML leave of absence, and if premium is paid, *Your* coverage will be continued through the end of the month that immediately follows the month in which *Your* leave of absence begins.

If the *Policyholder* has approved more than one type of leave of absence for *You* during any one period that *You* are not Actively at Work *We* will consider such leaves to be concurrent for the purpose of determining how long *Your* coverage may continue under the Policy.

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

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

In no event will *Your* coverage under the policy be continued beyond the date *Your* coverage would otherwise end according to the terms of the *When will Your insurance terminate?* provision.
00033

DAY CARE EXPENSE BENEFIT

Are Day Care Expense Benefits available while You are Disabled?

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

Day Care Expenses mean monthly expenses, up to $350.00 per child per month, to a maximum total benefit of $1,000.00 per month, charged by a licensed day care provider who is not a member of *Your* immediate family or living in *Your* residence.

Eligible Child means *Your Dependent Child* under age 13 who lives with *You.*

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

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

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

00034

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

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

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

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

Eligible Survivor means *Your Spouse*, if living, or if *Your Spouse* dies before the final monthly benefit is paid, then *Your* children who are under age 25.

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

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

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

If there is no *Eligible Survivor*, *We* will pay the Survivor Income Benefit to *Your* estate.
00036-GA

REHABILITATION BENEFIT

What is the Rehabilitation Benefit?

If *You* are receiving a *Monthly Benefit* and *You* are participating in a *Rehabilitation Plan* approved by *Us* , *You* will receive a monthly *Rehabilitation Benefit*. The *Rehabilitation Benefit* pays 10% of *Your Gross LTD Monthly Benefit* to a maximum of $1,000.00 per month subject to the maximum *Monthly Benefit* as shown in the *Schedule of Benefits*.

Eligibility for a *Rehabilitation Plan* is based upon *Your* education, training, work experience and physical and/or mental capacity. To be considered for a *Rehabilitation Plan*:

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

The Rehabilitation Benefit is not subject to policy provisions which would otherwise increase or reduce the *Monthly Benefit*.

Rehabilitation Benefit payments will end on the earliest of the following dates:

1. after 6 monthly Rehabilitation Benefit payments have been made;
2. on the date *We* determine that *You* are no longer eligible to participate in a *Rehabilitation Plan*;
3. on the date *You* are no longer participating in the *Rehabilitation Plan*; or
4. on any other date monthly payments would cease in accordance with the Policy.

00039

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 Monthly Benefit*.

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

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

Last Monthly Benefit means the monthly benefit paid to *You* immediately prior to *Your* request for benefits under the Worksite Modification Benefit provision, but not including any reductions for *Deductible Sources of Income*.
00044

CLAIM SERVICES

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

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

Vocational Rehabilitation Service

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

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

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

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

Social Security Disability Assistance

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

00047

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Written Proof of Loss

Within 10 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 10 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 *You*r proof of loss. Failure to provide complete proof of loss may delay, suspend or terminate Your benefits.

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

9. The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.

10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be made as often as reasonably necessary. If required, this will be at Your expense and must be received within 45 days of *Our* request. Failure to comply with such a request may delay, suspend or terminate *Your* benefits.

Examination

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

Authorization and Documentation *You* will be asked to supply

1. *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information in support of *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.

2. *You* will be required to supply proof that *You* have applied for other Deductible Sources of Income such as Workers' Compensation or Social Security *Disability* benefits, when applicable.

3. *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Sources of Income. *You* must tell *Us* the nature of the Deductible Source of Income, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

00048-GA

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit on a monthly basis, so long as *You* continue to qualify for it. Any balance remaining unpaid upon the termination of the period of liability will be paid immediately after We receive due written proof. Valid claims not paid according to these terms will be increased by interest at the rate of 18% per annum until finally settled.

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.

00049-GA

Can You assign Your benefits?

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

What will happen if a claim is overpaid?

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

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

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

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*. *We* will bear any expenses associated with *Our* pursuit of subrogation or recovery.
00050

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the *Policyholder's* application, the employee's certificate of coverage, and *You*r 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 *U*s:

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

Clerical Error

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

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

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

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

Misstatement of Age

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

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

Incontestability

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

Conformity with State Statutes and Regulations

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

Workers' Compensation or State Disability Insurance

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

Agency

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

General Provisions

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

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

whichever is later.

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

00051

DEFINITIONS

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

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.
00052

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

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

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

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); and
6. emergency leave of absence (except emergency medical leave).

00053

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain maximum medical improvement.
00055

Date of Disability is the date *We* determine that *You* are *Disabled*.
00057

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

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

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

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

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

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

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

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

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

Employee means an *Actively at Work* full-time *Employee* whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, who is *Actively at Work* for at least the number of hours per week as stated in the Application and is reported on the *Policyholder's* records for Social Security and withholding tax purposes.
00069

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

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

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

Indexed Monthly Earnings means *Your Monthly Earnings* adjusted on each anniversary of benefit payment by the lesser of 3% or the current annual percentage increase in the *Consumer Price Index*. *Your Indexed Monthly Earnings* may increase or remain the same, but will never decrease.

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

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

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

LTD means Long Term Disability.
00070

Male pronoun, whenever used, includes the female.
00071

Material and Substantial Duties means duties that:

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

00072

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

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

00073

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

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

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

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

00078

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

Participation in a Riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken

in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.
00080

Pre-existing Condition means a condition which;

1. was caused by, or results from a *Sickness* or *Injury* for which *You* received medical treatment, or advice was rendered, prescribed or recommended within 6 months prior to *Your* effective date; and

2. results in a Disability which begins in the first 12 months after *Your* effective date.
00081-GA

Regular Occupation means the occupation that *You* are routinely performing when *Your Disability* begins. *We* will look at *Your* occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific *Policyholder* or at a specific location.
00082

Rehabilitation Plan means a written agreement between *You* and *Us*. Its purpose is to assist *You* in returning to *Gainful Employment*. The *Rehabilitation Plan* will outline the time and dates of the vocational rehabilitation services, *Our* responsibilities, *Your* responsibilities and the responsibilities of any third party which might be involved. The *Rehabilitation Plan* will be at *Our* expense, at the expense of the third party, or a shared expense of *Ours* and a third party. At Our discretion, the Rehabilitation Plan will include the Day Care Expense Benefit.
00083

Riot shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.
00085

Schedule of Benefits means the schedule which is a part of this certificate.
00086

Sickness means sickness or disease causing *Disability* which begins while *You* are covered under the Policy.
00087

Special Conditions means

1. muscoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, except:

    a. Arthritis;

    b. Herniated Invertebrate Discs;

    c. scoliosis;

    d. spinal fractures;

    e. osteopathies;

    f. spinal tumors, malignancy, or vascular malformations;

    g. radiculopathies, documented by elkectromyogram;

    h. spondylolosthesis, grade II or higher;

    i. myelopathies and myelitis;

    j. demyelinating disease;

    k. traumatic spinal cord neurosis;

    l. myofacial pain syndrome;

2. chronic fatigue syndrome;
3. fibromyalgia;
4. carpal tunnel syndrome, or
5. environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity.

00088

Spouse means lawful spouse in the jurisdiction in which *You* reside. *Spouse* will include *Your Domestic Partner*.
00091

Substance Abuse means a pattern of pathological use of alcohol or other psychoactive drugs resulting in impairment of social and or occupational functioning; debilitating physical condition; inability to abstain from or reduce consumption of the substance; or the need for daily substance use for adequate functioning.
00092

Waiting Period as shown in the Schedule of benefit means the continuous length of time immediately before Your Effective Date during which You must be in an Eligible Class. Any period of time prior to the Policy Effective Date You were Actively at Work for Your Employer will count towards completion of the Waiting Period.
00093

We, Our and ***Us*** mean the Dearborn National Life Insurance Company, Chicago, Illinois.
00094

You, Your and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
00095

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, 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 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 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 policy ("Policy") issued by Dearborn National Life Insurance Company (“Dearborn National” 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") established by your employer ("the Company").

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 Dearborn National. As claims administrator, Dearborn National 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 Dearborn National and shall be effective as of the date agreed to, in writing by the Plan Sponsor and Dearborn National. 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). 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 Dearborn National at:

Claims Department

Dearborn National Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

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 Dearborn National uses electronic notices, it will do so in accordance with 29 CFR 2520.104b- 1c(i), (iii) and (iv).

Disability Insurance Plans

Dearborn National 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, Dearborn National notifies 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, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provision(s) on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

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.

Dearborn National 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, Dearborn National notifies 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.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- 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 for benefits;
- a statement of the claimant's right to bring action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as medication. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Administrative Office:
1020 31st Street • Downers Grove, IL 60515-5591