

Voluntary Short Term Disability Insurance

Employee Benefit Booklet



CITY OF GREENVILLE

F023089-0001

Class 1-03

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands and Puerto Rico.

01/18/2019

**Dearborn National[®] Life Insurance
Company**

Administrative Office:
1020 31st Street
Downers Grove IL 60515-5591
(800) 348-4512

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

Having issued Group Policy No. F023089-0001

(herein called the Policy)

to

CITY OF GREENVILLE

(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.

Note: These forms contain a pre-existing condition exclusion which may allow Us to deny coverage for certain disabilities. Consult Your certificate for details.


THIS IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Us upon request.

THIS CERTIFICATE IS RENEWABLE AT THE OPTION OF DEARBORN NATIONAL LIFE INSURANCE COMPANY

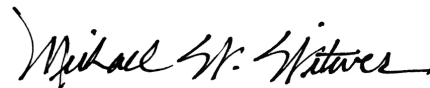
00098 NC

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn National Life Insurance Company



Secretary



President

Voluntary Group Short Term Disability Insurance Certificate
Non-Participating

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

SHORT TERM DISABILITY BENEFITS

EXCLUSIONS AND LIMITATIONS

TERMINATION OF COVERAGE

SUPPLEMENTAL BENEFITS

 WORKSITE MODIFICATION BENEFIT

 SURVIVOR INCOME BENEFIT

FILING A CLAIM

UNIFORM PROVISIONS

DEFINITIONS

SCHEDULE OF BENEFITS

Policyholder:	CITY OF GREENVILLE
Policy Number:	F023089-0001
Effective Date:	01/01/2019
Annual Enrollment Period:	As determined by the Policyholder
Eligibility: Class 03	All active full-time Employees enrolled in the 90/90 EP Plan of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time Employee is one who regularly works a minimum of 40 hours per week for the Policyholder. Part-time, seasonal and temporary Employees of the Policyholder are not eligible.
Eligibility Waiting Period:	<u>Current Employees</u> If You are in a class eligible for insurance on or before the Policy Effective Date: First of the month following Date of Hire of continuous, full-time Active work <u>New Employees</u> If You enter a class eligible for insurance after the Policy Effective Date: First of the month following Date of Hire of continuous, full-time Active work
Short Term Disability STD Benefit Percentage	As selected by You, from a minimum of \$100.00 per week to a maximum of \$1,200.00 per week, in increments of \$100.00. The amount selected cannot exceed 60% of Your weekly salary.
Minimum STD Weekly Benefit	\$100.00
Elimination Period	90 Days - Injury 90 Days - Sickness
Benefits are Payable on	Day 91 of Injury Day 91 of Sickness; or 1st Day of Hospital confinement, whichever is earlier.
Maximum Period Payable	104 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
- Worksite Modification
- Survivor Benefit
- FMLA Coverage Extension

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

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

All active full-time Employees enrolled in the 90/90 EP Plan of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time Employee is one who regularly works a minimum of 40 hours per week for the Policyholder. Part-time, seasonal and temporary Employees of the Policyholder are not eligible.

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 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 on the first of the month that falls on or next follows the date You sign the Enrollment Form;
4. If You do not sign the Enrollment Form within this 31-day period, You must wait until the next Annual Enrollment to apply for coverage, 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.
 - 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 You sign the Enrollment Form.

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.

00003

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, provided the benefit change is consistent with the Change in Family Status. You must submit the appropriate Enrollment Form within 31 days of the Change in Family Status.

00004

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

1. You get married or execute a Domestic Partner affidavit;
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.

00005-A

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.

00007

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

If You are absent from Active Work on the date Your coverage would otherwise become effective; and Your absence is caused by an Injury, illness or layoff,

Your effective date for any initial coverage or increased coverage will be deferred until the first day You return to Active Work. However, You will be considered Actively at Work on any day that is not Your regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if You were Actively at Work on the immediately preceding scheduled work day and You were:

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

00008

Changes to Your coverage

A change in Your coverage may occur if:

1. You enroll for a different coverage option; or
2. There is a Policy change; or
3. You enter another class and become eligible for a change in benefits; or
4. You experience a qualified Change in Family Status.

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

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

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

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

Any decrease in coverage will take effect immediately.

Exception: Increases or decreases to Your Voluntary Benefit program elected during the Annual Enrollment Period will become effective on the Policy anniversary date, provided You are Actively at Work on that day.

00009

Who pays for Your coverage?

You pay the entire cost of Your coverage.

00010

What happens if We are replacing an existing Policy?

Effect on Actively at Work requirement

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

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

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

Effect on Benefits

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

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

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

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 Weekly Benefit will be the lesser of:
 - a. The Weekly Benefit that would have been payable under the terms of the Prior Policy if it had remained in force; or
 - b. The Weekly 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.

00012

Eligibility after You Terminate Employment

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

00013

SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or **Disabled** means that You satisfy the definition of Total Disability or Partial Disability and You are receiving Appropriate and Regular Care for Your condition from a Doctor, except that the Appropriate and Regular Care from a Doctor will no longer be required if You are Disabled under the terms of the Policy and have reached Your maximum point of recovery.

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

00014 NC

How do We define Total Disability?

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

00015

How do We define Partial Disability?

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

1. During the Elimination Period You are able to perform some but not all of the Material & Substantial Duties of Your Regular Occupation; and
2. After the Elimination Period, due to Injury or Sickness, You are able to perform some but not all of the Material and Substantial Duties of Your Regular Occupation, and Your Disability Earnings, if any, are at least 20% but less than or equal to 80% of Your pre-disability Weekly Earnings.

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

00017

Loss of Professional License or Certification

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

00019

What is the Elimination Period and how is it satisfied?

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

If You temporarily recover and return to work, We will treat Your Disability as continuous if You return to work for a period of less than or equal to one-half the Elimination Period rounded up to the next whole number, not to exceed 14 days. The days that You are not Disabled will not count toward Your Elimination Period.

If You return to work for a period greater than one-half the Elimination Period, or 14 days, whichever is less, and become Disabled again, You will have to begin a new Elimination Period.

00020

Can You satisfy Your Elimination Period if You are working?

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

00021

What Disability Benefit are You eligible to receive?

If You are Disabled and receiving Appropriate and Regular Care for Your condition from a Doctor or if You no longer require Appropriate and Regular Care from a Doctor because You have reached Your maximum point of recovery, You are eligible to receive one of the following at any given time:

1. an STD Weekly Benefit; or

2. a Work Incentive Benefit.

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

00022 NC

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

Your STD Weekly Benefit will be based on the amount You selected as reported to Us by the Policyholder 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. Take the amount You have selected at enrollment not to exceed 60% of Weekly Earnings;
2. The maximum Gross STD Weekly Benefit is \$1,200.00.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is Your Gross STD Weekly Benefit.
4. Subtract the Deductible Sources of Income from Your Gross STD Weekly Benefit. The resulting figure is Your Net STD Weekly Benefit.

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

00023-B

Can You work and still receive benefits?

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

00025

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

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

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

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

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

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

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

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

00026

When are benefits payable if You are Hospital Confined?

If You are Hospital Confined during the Elimination Period, STD Weekly Benefits will become payable on the first day You are Hospital Confined, and the remainder of the Elimination Period will be waived. The Maximum Period Payable will begin on the date Your STD Weekly Benefit becomes payable.

You must be seen regularly and treated by a Doctor while You are Hospital Confined.

Confined means that You are registered as an inpatient in a Hospital upon the recommendation of a Doctor or as an outpatient in a Hospital because of surgery. You are not Confined if You are receiving emergency treatment or if You are hospitalized solely because of non-surgical medical or diagnostic test.

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.

00027

What are the Deductible Sources of Income?

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

1. Disability benefits paid under:
 - a. any state compulsory disability benefit Act or Law.
 - b. any group insurance plan provided by or through the Policyholder.
 - c. any Workers' Compensation or Occupational Disease Act or Law, or any other Law which provides compensation for an occupational Injury or Sickness.

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

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.
 13. Disability benefits paid under any No Fault Auto Motor Vehicle coverage.
- 00028 NC

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

The Net STD Weekly Benefit payable for Disability will not be less than \$100.00. The minimum Net STD Weekly Benefit does not apply if You are Gainfully Employed.

00029

What happens if Your Deductible Sources of Income increase?

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

00030

How long will You receive benefits under the Policy?

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

00031

What happens if Your Disability recurs?

If Disability for which benefits were payable ends but recurs due to the same or related causes less than 14 days after the end of a prior Disability, it will be considered a resumption of the prior Disability. Such recurrent Disability shall be subject to the provisions of the Policy that were in effect at the time the prior Disability began.

Disability which recurs more than 14 days after the end of a prior Disability is subject to:

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

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

00032

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

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

1. loss of professional license, occupational license or certification.
2. a Pre-existing Condition;
3. commission of, participation in, or an attempt to commit an assault or felony;
4. Intentionally self-inflicted injuries;
5. attempted suicide, regardless of mental capacity;
6. Cosmetic Surgery except when required due to Injury or Sickness;
7. Occupational Injury or Sickness for which benefits under any Worker's Compensation or similar law are paid or payable to the insured;
8. participation in a war, declared or undeclared, or any act of war.

Furthermore:

1. Benefits are not payable if Your Disability Earnings exceed 80% of Your pre-disability Weekly Earnings.
2. Benefits are not payable if You are able to return to work in Your Regular Occupation on a part-time basis but You do not.
3. Benefits are not payable for any period during which You are confined to a penal or correctional institution if the period of confinement exceeds 30 days.

00033.1 NC

TERMINATION OF COVERAGE

When will Your insurance terminate?

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

1. the date on which the Policy is terminated;
2. the date You stop making any required contribution toward payment of premiums;
3. the date You:
 - a. are no longer a member of a class eligible for this insurance,
 - b. request termination of coverage under the Policy,
 - c. are retired or pensioned, or
 - d. cease work because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute, unless We and the Policyholder have agreed in writing in advance of the leave to continue insurance during such period.

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

00034

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

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

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

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

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

While granted a Family or Medical Leave of Absence:

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

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

We will not:

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

00035

SUPPLEMENTAL BENEFITS

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

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

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

1. \$1,500.00; or
2. 2 times Your Last STD Weekly Benefit.

We will reimburse the Policyholder upon completion of the following:

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

For the purposes of this provision, Last STD Weekly Benefit means the weekly benefit paid to You immediately prior to Your request for benefits under the Worksite Modification Benefit provision, but not including any reductions for Deductible Sources of Income.

00038

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

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

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

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

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

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

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

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

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

00039

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Telephonic Claim Notification

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

Claim Forms

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.

Proof of Loss

You must furnish Us with written proof of loss within 180 days after the termination of the period for which We are liable. If it is not possible to give Us written proof within 180 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. Unless You are Disabled under the terms of the Policy and You have reached Your maximum point of recovery, proof that You are receiving Appropriate and Regular Care for Your condition from a Doctor, who is someone other than You or a member of Your immediate family, whose specialty or expertise is the most appropriate for Your disabling condition(s) according to Generally Accepted Medical Practice.
5. Objective medical findings which support Your Disability. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for Your disabling condition(s).
6. The extent of Your Disability, including restrictions and limitations which are preventing You from performing Your Regular Occupation.
7. Appropriate documentation of Your Weekly Earnings.
8. If You were contributing to the premium cost, the Policyholder must supply proof of Your appropriate payroll deductions.
9. The name and address of any Hospital or health care facility where You have been treated for Your Disability.
10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of Disability

You may be asked to submit proof that You continue to be Disabled and are continuing to receive Appropriate and Regular Care of a Doctor. Requests of this nature will only be made as often as reasonably necessary. 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.

Appropriate and Regular Care from a Doctor is not required if You are Disabled under the terms of the Policy and have reached Your maximum point of recovery.

Examination

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

Authorization and Documentation You will be asked to supply

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

00040 NC

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.

00041

UNIFORM PROVISIONS

Entire Contract; Changes

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

Statements on the Application

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

1. the Policyholder in applying for the Policy will make it void unless the representation is contained in the signed Application; or
2. any Employee in applying for insurance under the Policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the Employee, is or has been given to the Employee.

Legal Actions

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

1. until 60 days after proof of loss has been given; or
2. more than 3 years after proof of loss 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.

Incontestable

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. After two years from Your effective date of coverage no misstatement, except misstatements made by You in the application for coverage under the Policy shall be used to void the coverage under the Policy or deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

Conformity with State Statutes and Regulations

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

Workers' Compensation or State Disability Insurance

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

00043 NC

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.

00044

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 or Canada;
4. are paid regular earnings by the Policyholder, and
5. not a temporary or seasonal Employee.

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

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

You were not Hospital Confined or Disabled due to an Injury or Sickness.

00045

Accumulated Sick Leave or Salary Continuation means continued payments to You by Your Employer of all or part of your Weekly Earnings after You become Disabled as defined by the Policy. This continued payment must be part of an established plan maintained by 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.

00046

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

00047

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.

00048

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

00049

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

Appropriate and Regular Care from a Doctor is not required if You are Disabled under the terms of the Policy and have reached Your maximum point of recovery.

00050 NC

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

00051

Confined means that You are registered as an inpatient in a Hospital upon the recommendation of a Doctor or as an outpatient in a Hospital because of surgery. You are not Confined if You are receiving emergency treatment or if You are hospitalized solely because of non-surgical medical or diagnostic test.

00052

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

00053

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

00054

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

If Your Disability Earnings routinely fluctuate widely from week to week, We may average Your Disability Earnings over the most recent three weeks to determine if Your claim should continue. If We average Your Disability Earnings, We will not terminate Your claim unless the average of Your Disability Earnings from the last three weeks exceeds 80% of Your Weekly Earnings.

00055

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

00056

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

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

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

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

00057

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

00058

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

00059

Employee means an Actively at Work full-time, non-seasonal 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 (30 hours per week minimum) and is reported on the Employer's records for Social Security and withholding tax purposes. Persons employed on a part-time, temporary or substitute basis are excluded.

00060 NC

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

00063

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

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

Hospital means either of the following:

1. A licensed Hospital which
 - a. maintains on the premises all facilities necessary for major surgical treatment,
 - b. provides such treatment on an inpatient basis for compensation under the full-time supervision of licensed physicians, and
 - c. provides 24-hour service by registered graduate nurses.
2. A free-standing surgical facility which maintains on the premises all facilities necessary for major surgical treatment.

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

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.
00067

Last STD Weekly Benefit, for the Worksite Modification Benefit, means the weekly benefit paid to You immediately prior to Your request for benefits under the Worksite Modification Benefit provision, but not including any reductions for Deductible Sources of Income.
00068

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

Male pronoun, whenever used, includes the female.
00070

Material and Substantial Duties means duties that:

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

00071

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an Injury or Sickness can no longer be reasonably anticipated.
00072

Maximum Period Payable, as shown in the Schedule of Benefits, means the longest period of time that We will make payments to You for any one period of Disability.
00073

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

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

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 6 months after Your effective date.

00079 NC

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

00080

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

00081

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

00082

Sickness means Sickness or disease causing Disability which begins while You are covered under the Policy. Sickness includes pregnancy and Complications of Pregnancy. Complications of Pregnancy means that part of Your pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the delivery or after delivery.

00083 NC

Spouse means lawful Spouse. Spouse will include Your Domestic Partner.

00084a

STD means Short Term Disability.

00085

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

00086

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

00087

Weekly Earnings means Your gross weekly income from Your Employer in effect just prior to Your Date of Disability. It includes Your total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.

00088

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

00089

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

00090

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina, 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

- (1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- (2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- (3) The guaranty association will pay a maximum of \$500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
- (4) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- (5) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

END OF CERTIFICATE



Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands and Puerto Rico.