BlueCross BlueShield of Montana

Voluntary Accidental Death & Dismemberment Insurance

Member Benefit Booklet

STATE OF MONTANA

F026969-0001

Class 1-01

Rev. 10/01/2022

DEARBORN LIFE INSURANCE COMPANY
(A stock life insurance company, herein called "*We*" "*Us*" or "*Our*")

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

Having issued Group Policy No. **F026969**

(herein called the *Policy*)

to

STATE OF MONTANA
(herein called the *Policyholder*)

GROUP ACCIDENTAL DEATH & DISMEMBERMENT CERTIFICATE

CERTIFIES that *You* are insured, provided that *You* qualify under the ELIGIBILITY and EFFECTIVE DATE 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*, and it takes effect as stated in the ELIGIBILITY and EFFECTIVE DATE 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 Group Insurance Certificate (issued to *You*) are different from the *Policy* (issued to the *Policyholder*), the *Policy* will govern. *Your* coverage may be canceled or changed in accordance with the terms and provisions of the *Policy*.

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Accidental Death & Dismemberment Group Insurance Certificate
with Dependent Accidental Death & Dismemberment Benefits
Non-Participating
Guaranteed Renewable

THIS IS AN ACCIDENT ONLY CERTIFICATE

THIS IS NOT A WORKERS' COMPENSATION POLICY

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SCHEDULE OF BENEFITS STATE OF

POLICYHOLDER: MONTANA

POLICY NUMBER: F026969-0001

POLICY EFFECTIVE DATE: January 1, 2022 (Revised effective January 1, 2023)

ANNUAL ENROLLMENT PERIOD: as defined by the Policyholder

ELIGIBILITY:
Class 01

All active *Members* enrolled in the State Sponsored Health Plan of the *Policyholder* working in the United States of America who are *Actively at Work* for the *Policyholder* and who have completed the Eligibility *Waiting Period* are eligible for the insurance.

Eligibility Waiting Period:

Current *Members*: None

New *Members*: Elected officials are eligible on the date they take the oath of office, but not before the date their term begins.

All other *Members* are eligible on the date *You* become a *Member*.

Policyholder Contribution:

Voluntary Accidental Death & Dismemberment	0% of premium
Dependent Accidental Death & Dismemberment	0% of premium

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

Individual Plan	**Principal Sum**
Member Voluntary Coverage Amount	*Member* election between $25,000 and $1,000,000 in increments of $25,000
Newborn *Child* (moment of birth to 31 days)	20% of the *Member Principal Sum*

Family Plan	**Principal Sum**
Member Voluntary Coverage Amount	*Member* election between $25,000 and $1,000,000 in increments of $25,000
Dependent Benefit Amount	
Spouse	50% of the *Member Principal Sum* if there are no covered *Dependent Children* 40% of the *Member Principal Sum* if there are covered *Dependent Children*
Dependent Child(ren) Live Birth to age 26	10% of the *Member Principal Sum* if there is no covered *Dependent Spouse* 10% of the *Member Principal Sum* if there is a covered *Dependent Spouse*

Reduction of Benefits None. Benefits terminate at retirement.

INCLUDED BENEFITS

Air Bag Benefit	5% of *Covered Person's Principal Sum*, to a maximum of $10,000
Day Care Benefit	3% of *Covered Person's Principal Sum* to a maximum of $3,000 per year per Child for a maximum of 5 years
Education Benefit	3% of *Covered Person's Principal Sum* to a maximum of $3,000 per year per Child for a maximum of 4 years

Felonious Assault Benefit	10% of the *Covered Person's Principal Sum* to a maximum of $25,000
In the Line of Duty Benefit	50% of *Your Principal Sum* to a maximum of $250,000
Seat Belt Benefit	10% of the *Covered Person's Principal Sum* to a maximum of $25,000
Spouse Training Benefit	5% of *Your Principal Sum* to a maximum of $10,000

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the *Schedule of Benefits*.

When does Your Contributory insurance become effective?

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

You may enroll for insurance coverage at any time. *Your Contributory* coverage will become effective on the latest of the following dates provided *You* are *Activelyat Work* on that date:

1. If *You* enroll for coverage prior to the *Policy Effective Date*, the *Policy Effective Date*; or
2. If *You* enroll for coverage after the effective date on the date *You* sign the *Enrollment Form*; or
3. If *You* enroll during an *Annual Enrollment Period*, the next *Anniversary Date* following the *Annual Enrollment Period*

Enrollment Form means the form *You* complete to enroll for coverage under the *Policy*.

When does Dependent insurance become effective?

Your Dependent's coverage will become effective the latest of:

1. The date *Your* insurance becomes effective under the *Policy*, If *You* have enrolled for *Dependent* coverage on or before that date; or
2. The first day of the month following the date *You* enroll for *Dependent* coverage.

When does coverage for a new Spouse become effective?

Coverage for a new *Spouse* starts automatically at *Your* marriage, if *You* have not previously elected *Dependent* coverage. Such *Spouse* will be a *Covered Person* for 31 days. The *Spouse* will cease to be a *Covered Person* unless:

1. *You* request, in writing, and within such period noted above, continuation of such *Dependent* coverage; and
2. The required premium, if any, is paid.

If additional premium is required for such *Spouse*, premium will be charged from the date of marriage.

When does coverage for a newborn Child become effective?

Coverage for a newborn *Child* starts automatically from the moment of birth if a *Child* is born to *You* and *You* have not previously elected *Dependent* coverage. The newborn *Child* will be a *Covered Person* for 31 days. The newborn *Child* will cease to be a *Covered Person* unless:

1. *You* request, in writing, and within such period noted above, continuation of such *Dependent* coverage; and
2. The required premium, if any, is paid.

If additional premium is required for such *Child*, premium will be charged from the date of birth.

Dependent coverage will also be extended to newly adopted, foster or step *Children*, as of the date they become financially dependent on *You* for support, provided they otherwise meet the definition of a *Dependent Child*.

What is an Annual Enrollment Period?

Unless otherwise specified, *Annual Enrollment Period* means a period of time during which eligible *Members* may enroll for coverage or request changes to their benefit plan. The *Annual Enrollment Period* is shown on the *Schedule of Benefits*.

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.

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

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*.

If a change results in additional coverage, for reasons other than a *Policy* change, the change will be effective the first of the month following the later of:

1. The date *You* enroll for the additional coverage; or
2. The date *You* become eligible for the additional coverage, if enrollment is not required.

Additional *Contributory* coverage is subject to payment of premium.

If a change results in a decrease in coverage the change will take effect immediately.

Exception: Increases or decreases to *Your* benefit program elected during the *Annual Enrollment Period* will become effective on the next *Policy* anniversary date.

Eligibility after You Terminate Employment

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

Exception: If *Your* coverage ends due to termination of employment and *You* return to *Active Work* in an eligible class within 90 days, *We* will not apply a new Eligibility Waiting Period, if applicable.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Coverage Plans Available

Individual Plan: If *You* enroll in the *Individual Plan*, *You* may select a *Principal Sum* within the range set forth in the Schedule of Benefits, and *You* will be covered for the amount selected while coverage remains in force, subject to any adjustments resulting from an increase in age.

Family Plan: If *You* enroll in the *Family Plan*, *You* may select a *Principal Sum* within the range shown on the Schedule of Benefits, and *Your Eligible Dependents* will be covered for a percentage of *Your Principal Sum* as shown on the Schedule of Benefits, subject to any adjustments resulting from an increase in age.

What is the Accidental Death & Dismemberment Benefit?

If a *Covered Person* suffers an *Injury* in an *Accident, We* will pay for those *Losses* set forth in the Table of Losses below. The amount paid will be the percentage stated in the Table of Losses but not more than the *Principal Sum* set forth in the Schedule of Benefits. The *Loss* must:

1. occur within 365 days of the *Accident*; and
2. be the direct and sole result of the *Accident*; and
3. be independent of disease or bodily infirmity.

TABLE OF LOSSES	**% OF PRINCIPAL SUM and/ or MAXIMUM PAYABLE**
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Speech and Hearing	100%
Quadriplegia	100%
Paraplegia	75%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia	50%
Loss of Thumb and Index Finger (on same hand)	25%
Uniplegia	25%

The total amount of benefits payable for all losses above, for any *Covered Person* resulting from any one *Accident*, will not be greater than the *Principal Sum* set forth in the Schedule of Benefits.

Except as provided in a particular benefit provision, *We* will pay benefits for Loss of Life to the beneficiary(ies) named. Benefits for all other *Losses* will be paid to *You*.

When is an Accidental Death Benefit payable?

We will pay *Your* beneficiary the amount of coverage in force as of the date of *Your Accidental* death provided:
1. *You* are insured under the *Policy* on the date of death, and
2. *We* receive proof of death within two (2) years after the date of death.

We will determine the amount of insurance payable based upon the Schedule of Benefits.

Who will receive Your Accidental Death Benefits?

Your primary beneficiary means the person or persons *You* name to receive death benefits under the *Policy*. *Your* contingent beneficiary is the person or persons *You* name to receive death benefits if *Your* primary beneficiary does not survive *You. You* may name more than one beneficiary. If *You* name two or more beneficiaries, payment of proceeds will be apportioned equally unless *You* specify otherwise.

You must make *Your* beneficiary designation on a form which *We* provide or on a form accepted by *Us.* The *Policyholder* may not be named as beneficiary. Unless *You* provide otherwise, if a beneficiary dies before *You*, *We* will divide that beneficiary's share equally between any remaining named beneficiaries.

If *You* name an irrevocable beneficiary, *You* may not change the beneficiary without the consent of the irrevocable beneficiary. An irrevocable beneficiary has a vested interest in the proceeds of the contract. Therefore the contract holder cannot exercise certain rights without the permission of the irrevocable beneficiary.

If a beneficiary is a minor, or is not able to give a valid release for any payment of benefits made, *We* will not make payment until a claim is made by the person or entity which, by court order, has been granted control of the estate of such beneficiary. This provision does not prevent *Us* from making payment to or for the benefit of a minor beneficiary in accordance with the applicable state law.

Facility of Payment

If no named beneficiary survives *You* or if *You* do not name a beneficiary, *We* will pay the amount of insurance:
1. to *Your* spouse, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than $500 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death. Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.

May You change Your beneficiary?

You may change *Your* beneficiary at any time by completing a form provided or accepted by *Us*, and sending it to the *Policyholder*. *Your* written request for change of beneficiary will not be effective until it is recorded by the *Policyholder*. After it has been so recorded, it will take effect on the later of the date *You* signed the change request form or the date *You* specifically requested. If *You* die before the change has been recorded, *We* will not alter any payment that *We* have already made. Any prior payment shall fully discharge *Us* from further liability in that amount.

AIR BAG BENEFIT

What is the Air Bag Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits, if a benefit is payable for Loss of Life as the result of an *Accident* to a *Covered Person* which occurs while driving or riding in an *Automobile* provided that:

1. The *Covered Person* was positioned in a seat that was equipped with an *Air Bag*; and
2. The *Covered Person* was properly strapped in a *Seat Belt* when the *Air Bag* inflated; and
3. The police report establishes that the *Air Bag* inflated properly upon impact.

If it is unclear whether the *Covered Person* was properly wearing a *Seat Belt* or if it is unclear whether the *Air Bag* inflated properly, then the Air Bag Benefit will be $1,000.

This benefit is payable in addition to any other benefits provided in the *Policy*.

Definitions which apply to the Air Bag Benefit:

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the *Automobile*, or proper replacement parts as required by the automobile manufacturer's specification, that inflates upon collision to protect an individual from *Injury* and death. A *Seat Belt* is not an *Air Bag*.

Seat Belt means those belts that form an occupant restraint system.

DAY CARE BENEFIT

What is the Day Care Benefit?

This benefit applies if *You* are covered under the *Family Plan. We* will pay an additional amount, as set forth in the Schedule of Benefits, if the *Principal Sum* is payable for *Your* or *Your* covered *Spouse's* Loss of Life. The benefit is paid annually for the cost of covered expenses incurred, if *You* or *Your* covered *Spouse* are survived by a *Dependent Child* who:

1. On the date of the *Accident* was enrolled in a *Day Care Center* or is enrolled in a *Day Care Center* within 3 years from the date of the *Accident*; and
2. Is less than 13 years of age.

The Day Care Benefit is payable for incurred *Day Care Center* expenses for each *Child* who qualifies:

1. In an amount up to the Day Care Benefit Amount as set forth in the Schedule of Benefits; and
2. Only while the *Dependent Child* continues to be enrolled in a *Day Care Center*.

The benefit is payable in addition to any other benefits provided under the *Policy*.

We will pay this benefit once a year, at the end of the 12-month period in which there are documented *Day Care Center* expenses, for not more than the Maximum Day Care Benefit Duration, as set forth in the Schedule of Benefits, or until the *Dependent Child's* 13th birthday, whichever happens first.

If at the time of the *Accident*, coverage for a *Dependent Child* is in force, but there is no *Dependent Child* who qualifies, *We* will pay a one-time benefit of $1,000.

This benefit will be payable to *Your* surviving *Spouse*, if *Your Spouse* has custody of the *Child*. If *You* have no surviving *Spouse*, or *Your Child* does not live with *Your Spouse*, then the benefit will be paid to the *Child's* legally appointed guardian.

In the event of the death of *Your* covered *Spouse*, the benefit will be payable to *You*.

For the purposes of the Day Care Benefit, ***Day Care Center*** means a facility which is run according to law, including laws and regulations applicable to child care facilities, and which provides care and supervision for children in a group setting on a regular, daily basis.

A *Day Care Center* does not include: a hospital, the *Child's* home or care provided during normal school hours while a child is attending grades one through twelve.

EDUCATION BENEFIT

What is the Education Benefit?

This benefit applies if *You* are covered under the *Family Plan. We* will pay an additional amount, as set forth in the Schedule of Benefits, to *Your Dependent Student* if a benefit is payable for *Your* or *Your* covered *Spouse's* Loss of Life. *We* will only pay one Education Benefit to any one *Dependent Student* during any one school year. If the *Dependent Student* is a minor, *We* will pay the benefit to the legal representative of the minor.

This benefit is payable in addition to any other benefits provided under the *Policy*.

Definitions which apply to the Education Benefit:

Dependent Student means an *Eligible Dependent Child* who, on the date of *Your* or *Your Dependent Spouse's* death, is:
1. A full-time post-high school student in a *School of Higher Education*; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a *School of Higher Education* within 365 days after *Your* or *Your Dependent Spouse's* death.

School of Higher Education means an institution which:
1. Is legally authorized by the state in which it is located; and
2. Provides either a program for:
   a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
   b. Gainful employment as long as such program is at least one year of training; and
3. Is accredited by an agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

When Benefit Ends: A *Dependent Student* will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:
1. *Our* payment of the fourth installment of the Dependent Education Benefit on behalf of or to the *Dependent Student*; or
2. At the end of the period during which due proof must be submitted if no due proof is submitted.

If *Your* eligible *Dependent Child* does not qualify as a *Dependent Student*, but is enrolled in an elementary or high school, *We* will pay a one-time Child Education Benefit in the amount of $1,000. This benefit is payable once proof that *You* or *Your Dependent Spouse* died as a result of an *Accident* for which Loss of Life benefits are payable and that, within 12 months after *Your* or *Your Dependent Spouse's* death, *Your* eligible *Dependent Child* is a full-time student in an elementary or high school.

FELONIOUS ASSAULT BENEFIT

What is the Felonious Assault Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits, to *You* , or in the event of *Your* death, to *Your* designated beneficiary if:
1. Loss of Life occurs while *You* are on the *Business of the Policyholder* or commuting to or from the premises of the *Policyholder* and
2. Loss of Life is the direct result of any of the following:
   a. Robbery, holdup or attempt thereof; or
   b. Kidnapping while attempting a holdup; or
   c. Felonious assault inflicted by persons other than fellow *Members or* members of *Your* family or household.

This benefit is payable in addition to any other benefits provided under the *Policy*.

For purposes of the *Felonious Assault Benefit,* ***Business of the Policyholder*** means an assignment by or with the authorization of the *Policyholder* for the purpose of furthering the business of the *Policyholder*.

IN THE LINE OF DUTY BENEFIT

What is the In the Line of Duty Benefit?

We will pay an additional amount, as stated in the Schedule of Benefits, if *You* incur a *Loss* of Life as the direct result of an *Injury* sustained in an *Accident* while employed as a *Public Safety Officer* and on duty for the *Policyholder*.

This benefit is payable in addition to any other benefits provided under the *Policy*.

For purposes of the In the Line of Duty benefit a ***Public Safety Officer*** means a person whose primary job duties include, but are not limited, to controlling or reducing crime, criminal law and fire suppression.

SEAT BELT BENEFIT

What is the Seat Belt Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits, if a benefit is payable for *a Covered Person's* Loss of Life as the result of an *Accident* which occurs while driving or riding in an *Automobile*, if:

1. the *Automobile* is equipped with *Seat Belts*; and
2. the *Seat Belt* was in actual use and properly fastened at the time of the *Accident*; and
3. the position of the *Seat Belt* is certified in the official report of the *Accident* or by the investigating officer. A copy of the police accident report must be submitted with the claim; and
4. The *Covered Person* was driving or riding in an *Automobile* driven by a licensed driver who was neither:
    a. intoxicated or driving while impaired. Intoxication and impairment shall be determined, with or without conviction, by the law of the jurisdiction in which the *Accident* occurs or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication; nor
    b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance unless administered on the advice of a licensed *Doctor* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

If the required certification is not available and if it is unclear whether the *Covered Person* was properly wearing a *Seat Belt*, then *We* will pay an additional benefit of $1,000.

This benefit is payable in addition to any other benefits provided under the *Policy*.

For purposes of the Seat Belt Benefit, ***Seat Belt*** means those belts that form an occupant restraint system.

SPOUSE TRAINING BENEFIT

What is the Spouse Training Benefit?

This benefit applies if *You* are covered under the *Family Plan. We* will pay an additional amount, as set forth in the Schedule of Benefits, to *Your Dependent Spouse* if the coverage amount is payable for *Your* Loss of Life. The benefit payable is up to the Maximum Spouse Training Benefit set forth in the Schedule of Benefits. The benefit is paid annually for the cost of covered expenses incurred within 36 months of *Your* death.

We will pay this benefit if *You*:

1. Are enrolled in *Family Plan* coverage prior to the time of the *Accident*; and
2. Die within 365 days of and as a result of an *Accident*; and
3. Are survived by a covered *Spouse*.

The benefit will be payable for *Your* surviving *Spouse* who:

1. Was covered as a *Dependent Spouse* on the date of *Your Accident; and*
2. Enrolls within 3 years after *Your* death in any *School of Higher Education* for the purpose of training, retraining or refreshing skills needed for employment; and
3. Incurs expenses payable directly to or approved and certified by such school.

This benefit is payable in addition to any other benefits provided under the *Policy*.
For purposes of the Spouse Training Benefit, ***School of Higher Education*** means an institution which:

1. Is legally authorized by the State in which it is located; and
2. Provides either a program for:
   a. Bachelor's degrees or not less than a two year program with full credit towards a Bachelor's degree; or
   b. Gainful Employment as long as such program is at least one year of training; and
3. Is accredited by an agency or association recognized by the U.S. Department of Education under the Higher Education Assistance Act as may be amended from time to time.

EXPOSURE AND DISAPPEARANCE

If, as a result of an *Accident* while insured, a *Covered Person* is unavoidably exposed to the elements and suffers a *Loss* as a result of that exposure, that *Loss* will be covered. If the *Covered Person's* body has not been found within one (1) year of an *Accidental* disappearance, forced landing, sinking or wrecking of a conveyance in which the *Covered Person* was an occupant, the *Covered Person* will be deemed to have suffered Loss of Life.

LIMITATIONS AND EXCLUSIONS

Limitations:

We will not pay any benefit for *Loss* resulting from or caused by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any heart, coronary or circulatory malfunction; or
3. any infection, except a pus-forming infection of an *Accidental* cut or wound; or
4. attempted suicide, regardless of mental capacity; or
5. any intentionally self-inflicted *Injury*; or
6. war, declared or undeclared, whether or not a member of any armed forces; or
7. travel or flight in any aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; excluding losses while on State business and in an aircraft owned by the State of Montana; or
8. commission of, participation in, or an attempt to commit an assault or felony under a state or federal law; or
9. The *Covered Person* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a licensed *Doctor* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
10. The *Covered Person* being intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
11. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

Exclusions:

We will not pay any benefits for death or dismemberment if the death or dismemberment occurred while *You* were operating a motor vehicle and *You* were either:

1. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a licensed *Doctor* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
2. intoxicated as defined by the laws of the jurisdiction in which the death or dismemberment occurred or .08% blood alcohol content if such jurisdiction does not define intoxication. Conviction is not necessary for a determination of being intoxicated.

UNIFORM PROVISIONS

Initial Notice of Claim

We must receive written notice of loss within 30 days of the date of loss, or as soon as reasonably possible. If it is not possible to give *Us* written proof within 30 days, the claim is not affected if the proof is given as soon as possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and, if applicable, the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant 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 the *Loss*.

Time Limit for Filing Your Claim

We must receive written proof of loss within 90 days after the date a loss is incurred. 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 the claimant is legally incapacitated, written proof of loss must be given no later than one year after the time proof is otherwise due.

No benefits are payable for claims submitted more than one year after the time proof is due. However, benefits may be paid for late claims if it can be shown that:
1. It was not reasonably possible to give written proof during the one year period; and
2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

For the Education Benefit, proof of loss must:
1. Include proof of *Dependent Student* status; and
2. Be submitted no later than:
    a. Two months after completion of course work for that particular school year if the *Dependent Student* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall deemed to begin September 1st and end August 31st; or
    b. Within 6 months after enrollment in a *School of Higher Education* if the *Dependent Student* is in the 12th grade at the time of *Your* death.

After the first year in a *School of Higher Education*, due proof must be submitted in accordance with the time limits defined in Item (a.) above.

For the Spouse Training Benefit, proof of loss must:
1. Include proof of *Dependent Spouse* status; and
2. Be submitted no later than:
    a. Two months after completion of course work for that particular school year if the *Dependent Spouse* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall deemed to begin September 1st and end August 31st; or
    b. Within 6 months after enrollment in a *School of Higher Education* if the *Dependent Spouse* is in the 12th grade at the time of *Your* death.

After the first year in a *School of Higher Education*, due proof must be submitted in accordance with the time limits defined in Item (a.) above.

Right to Appeal an Adverse Decision on Your Claim

Any denied claim may be appealed to *Us* by *You* or *Your* authorized representative. The appeal request must be in writing and received by *Us* within 60 days of the date of the original claim denial, along with any new information, documents, or records relevant to the claim.

A decision will be made by *Us* no more than 60 days after receipt of *Your* completed request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. *We* will notify *You* in writing if an extension is needed. If *You* do not provide the information in that time period, *We* may decide *Your* appeal without that information.

Physical Examination/Autopsy

Upon receipt of a claim, *We* may examine an *Insured*, at *Our* expense, at any reasonable time. *We* reserve the right to perform an autopsy, at *Our* expense, if it is not prohibited by any applicable local law(s).

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for proof of loss, *We* will pay the claim within 30 days.

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Your coverage will terminate on the earliest of the following dates. Termination will not affect *Your* claim for a covered *Loss* which occurred while the coverage was in force.

1. the date on which the *Policy* is terminated; or
2. the first of the month following the date *You* stop making any required contribution toward payment of premiums; or if *You* were hired prior to August 1, 1998 and remained continuously covered by the State Plan, the last day of the calendar month next following the date the last period ends for which a premium contribution was made;
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
4. the first of the month following the date *You*
   a. are no longer a member of a class eligible for this insurance; or , if You were hired prior to August 1, 1998, the last day of the calendar month next following the date *You* are no longer a member of an eligible class,
   b. request termination of coverage under the *Policy;* or
   c. are retired or pensioned; or
   d. are no longer *Actively at Work* as a result of Temporary Layoff or Reduction in Force, *You* may continue to be eligiblefor group insurance coverage, until the end of the sixth month during which the temporary layoff or reduction in force began, provided all premiumsare paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group accidental death and dismemberment insurance provided by another carrier.
5. For term-limited Legislators, coverage terminates the first of the month following 6 months from the last day of the term in office.
6. For a period of time the *Policyholder* agreed to continue coverage, provided all premiums are paid when due.

For the purposes of this provision, ***Disability*** means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation*.

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, the *Policy* is in force and *Your* coverage is not replaced with group accidental death and dismemberment insurance with another carrier, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by FMLA and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under FMLA 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 an FMLA leave:

1. For Term-Limited Legislators, coverage terminates 6 months from the last day of the term in office.
2. For a period of time the *Policyholder* agreed to continue coverage, provided all premiums are paid when due.

5. For Term-Limited Legislators, coverage terminates 6 months from the last day of the term in office.

6. For a period of time the *Policyholder* agreed to continue coverage, provided all premiums are paid when due.

For the purposes of this provision, ***Disability*** means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation*.

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, the *Policy* is in force and *Your* coverage is not replaced with group accidental death and dismemberment insurance with another carrier, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by FMLA and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under FMLA 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 an FMLA leave:

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

When does Dependent coverage end?

Dependent coverage will end on the earliest of:

1. the first premium due date *You* are no longer an insured *Member* (except in the case of disability, layoff or leave of absence or sabbatical or military leave or Reserve-National Guard as set forth above); or
2. the date on which the *Policy* is terminated; or
3. the first premium due date *You* stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
5. the first premium due date *You*:

a. are no longer a member of a class eligible for this insurance; or

b. request termination of coverage under the *Policy*; or

c. are retired or pensioned; or

6. the date a *Dependent Child* or *Spouse* no longer meets the *Policy* definition of *Eligible Dependent*.

Note: Coverage will continue past the age limit for eligible *Dependent Children* who are primarily dependent upon *You* for support and who cannot work to support themselves due to a physical or intellectual disability which began before the age limit was reached. Proof of such incapacity must be provided to *Us* upon request.

GENERAL PROVISIONS

Entire Contract; Changes

The Entire Contract consists of:
1. The Group Insurance *Policy*;
2. The *Application*;
3. This *Certificate*;
4. The *Enrollment Forms* of the persons insured, including any individual statements; and
5. Any riders; endorsements; or amendments to the *Policy* or the *Certificate*.

Coverage under the *Policy* can be amended by mutual consent of 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

All statements made in any signed *Application*, or other written and signed statement, 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 other written and signed statement; or
2. any *Member* 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 *Member*, or other written and signed statement, is or has been given to the *Member*.

Legal Actions

Unless otherwise provided by federal law, no legal action brought to recover on the *Policy* of any kind may be filed against *Us*:
1. until 60 days after proof of claim has been given; or
2. no such action shall be brought after the expiration of any applicable statutes of limitations

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.

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. No statement *You* made relating to *Your* insurability under the *Policy* will be used to contest the validity of the insurance with respect to which such statement was made after such insurance has been in force for two years during *Your* lifetime, and in no event unless the statement is contained in a written instrument signed by *You* and a copy is given to *You* or to *Your* beneficiary.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates. The *Policyholder* agrees to and is responsible for remitting such premiums for the entire time coverage under the *Policy* is in effect.

Premium charges for increases in insurance amounts becoming effective during a *Policy* month will begin on the next premium due date. Premium charges for insurance terminating during a *Policy* month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If *You* have misstated *Your* age or the age of a *Dependent*, the true age will be used to determine:
1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

Conformity with Montana Statutes

The provisions of the *Policy* conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the *Insured* resides on or after the effective date of the *Policy*.

Assignment

Insurance, if any, on *Your Spouse* or *Child* is not assignable. *You* have the right to make an absolute assignment of all rights and interest under the *Policy* to any person permitted by law, subject to all of the following terms and conditions:

1. The assignment must transfer rights and interest of all insurance under the *Policy*. *You* may not make a collateral or partial assignment.
2. *Your* rights and interest under the *Policy* include, but are not limited to the following:
   a. the right to make contributions required to keep the insurance in force;
   b. the right to change the *Beneficiary*; and
   c. the right to convert.
3. The assignment will apply to all insurance under the *Policy* in effect on the date of the assignment or which becomes effective after that date. The assignment will have no effect unless it is made in writing, signed by *You*, and delivered to the *Policyholder* during *Your* lifetime. The assignment will take effect on the date *You* signed the assignment, provided the *Policyholder* receives it before benefits are paid or any other action is taken by *Us*. If *We* have paid benefits or taken any other action before the *Policyholder* receives *Your* designation, the assignment will not go into effect. Neither *We*, nor the *Policyholder* are responsible for the validity, sufficiency or effect of the assignment.
4. All insurance benefits will be paid in accordance with the beneficiary designation on file with the *Policyholder*, and the beneficiary provisions of the *Policy* (not to the assignee unless the assignee is also the Beneficiary). Any payment made by *Us* in accordance with the beneficiary designation on file with the *Policyholder* and the Beneficiary provisions of the *Policy* will fully discharge *Us* to the extent to the payment.
5. *You* may only change an absolute assignment made by *You* with written consent of the absolute beneficiary(s), and a copy of the written consent must be on file with the *Policyholder*.

You may not make any assignment which is inconsistent with these requirements.

On *Your* death, *Your* beneficiary may make an assignment of benefits to a funeral home provided that *We* receive written notice of the assignment prior to payment of any benefits. Any payment made by *Us* to a beneficiary prior to receiving notice of the assignment will fully discharge *Us* to the extent of the payment.

DEFINITIONS

This section tells *You* the meaning of special words and phrases used in this Certificate. To help *You* recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable. If the event is the result of *Your* plan, design, or intent, it is not *Accidental*. If the event was caused or contributed to by a disease or bodily infirmity, it is not *Accidental*.

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

1. performing the material duties of *Your* own occupation at *Your* Employer's usual place of business;
2. a legal citizen or resident of the United States of America or Canada; and
3. are paid regular earnings by the *Policyholder*.

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).

Application means the document signed by the *Policyholder* 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.

Automobile means a validly registered private passenger car (or *Policyholder*-owned car), station wagon, jeep-type vehicle, SUV, pick-up truck or van-type car that is not licensed commercially or being used for commercial purposes.

Covered Person means *You* and *Your Dependents* who are covered under the *Policy*.

Child includes:

1. A natural child; step-child; legally adopted child; a child who has been Placed For Adoption (must provide pre-adoption placement agreement) with *You or Your Spouse* and for whom as part of such placement, *You* or *Your Spouse* have a legal obligation for the partial or full support of such *Child,* including providing coverage under this *Policy* pursuant to a written agreement; a person for whom *You or Your Spouse* have been appointed the legal guardian by a court of competent jurisdiction prior to the *Child* attaining eighteen (18) years of age; and

2. Is less than twenty-six (26) years of age. This requirement is waived if the *Child* was mentally handicapped/challenged or physically handicapped/challenged provided that the *Child* is incapable of self-supporting employment and is chiefly dependent upon *You* for support and maintenance.

Child does not include the spouse of the *Dependent Child* or a *Child* of the *Dependent Child.*

Dependent or Eligible Dependent means a person who is a citizen, resident alien or is otherwise legally present in the United States or in any jurisdiction that *You* have been assigned by the *Policyholder* and for who a *Dependent* Verification has been submitted to the *Policyholder. Dependents* include:

1. *Your Spouse*
2. *Your Dependent Child.*

Dependent status is subject to Verification of *Dependent* Eligibility Requirements of the *Policyholder.*

A *Child* who is a full-time member of the military of any country does not qualify as a *Dependent.*

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 covered *Loss*, and the treatment provided by the practitioner is within the scope of his or her license.

Effective Date* – See *Policy Effective Date

Hemiplegia means the total *Paralysis* of the upper and lower limbs of the same side of the body.

Injury means bodily harm or damage resulting directly from an *Accident* and independent of all other causes.

Insured means the eligible *Member* whose insurance is in force under the terms of the *Policy*.

Male Pronoun whenever used includes the female.

Member means an employee of a participating department or agency of the State of Montana who is enrolled in the Employer-sponsored health plan, and one of the following

1. An employee of a department or agency of the judicial, legislative and executive branches of the State;
2. An elected official;
3. An officer of the legislative branch;
4. A judge;
5. An employee of Montana State Fund;
6. A member of the Legislature.

Member does not include a full-time member of the armed forces of any country, a leased employee, or an independent contractor.

Paraplegia means the total *Paralysis* of both lower limbs.

Policy means the contract between the *Policyholder* and *Us* including the attached *Application*, which provides group insurance benefits.

Policy Effective Date or ***Effective Date*** means the date stated on the *Schedule of Benefits*.

Policyholder means the person, firm, or institution to whom the *Policy* was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the *Policy*.

Principal Sum means the amount of accident insurance that applies to *You* and *Your* covered *Dependents* as shown or described in the Schedule of Benefits.

Quadriplegia means the total *Paralysis* of both upper and lower limbs.

Registered Domestic Partner or ***Domestic Partner*** means all of the following "Required Eligibility Conditions" are met:

1. *You* and *Your Domestic Partner* are both eighteen (18) years of age or older;
2. *You* and *Your and Domestic Partner* share a common residence;
3. Neither *You* nor *Your Domestic Partner* is married to any other person;
4. *You* and *Your Domestic Partner* are not legally related to each other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild;
5. *You* and *Your Domestic Partner* have a financially interdependent relationship as evidenced by at least one (1) of the following:
    a. Mutually granted powers of attorney or mutually granted health care powers of attorney; or
    b. Designation of each other as primary beneficiary in wills, life insurance policies or retirement plans.

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

Sickness means illness, disease, pregnancy or complications of pregnancy.

Spouse means lawful *Spouse*, according to the marriage laws of the state where the marriage was first solemnized or established. *Spouse* includes *Your Domestic Partner.*

Spouse does not include a spouse who is legally separated or divorced from You and has a court order or decree stating such from a court of competent jurisdiction, and regardless of a court order requirement to carry or pay for a legally separated or divorced Spouse's coverage.

A *Spouse* who is a full-time member of the military of any country is not eligible for benefits.

Uniplegia means the total *Paralysis* of one limb.

Voluntary means coverage for which *You* pay 100% of the premium.

We, Our and ***Us*** means Dearborn Life Insurance Company, Chicago, Illinois.

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

Dearborn Life Insurance Company™
(A stock life insurance company, herein called "We" "Us" or "Our")

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

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE OUTLINE OF COVERAGE

Read *Your Policy* **Carefully.** This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract. Only the actual policy provisions will control. The *Policy* itself sets forth the rights and obligations of both the *You* and Dearborn Life Insurance Company. It is, therefore, important that *You* READ YOUR CERTIFICATE CAREFULLY!

This coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of an Accidental Death or dismemberment.

The *Policy* pays a benefit to a covered insured, or a covered family member, in the event of an accidental death, accidental dismemberment, or other covered accidental loss. Full benefit payments are made for death. Depending on the benefits selected by the group, partial payments may be made for dismemberment and/or other losses.

Benefit payments can be made on a lump sum basis or monthly over a defined period of time. Depending on the losses covered, benefit payments can be in addition to the amount covered under the *Policy;* or, the benefit payment can result in a reduction to the remaining amount.

A. Description of Benefits

If a *Covered Person* suffers an *Injury* in an *Accident, We* will pay for those *Losses* set forth in the Table of Losses. The amount paid will be the percentage stated in the Table of Losses. The amount will not be more than the *Principal Sum* set forth in the Schedule of Benefits. The *Loss* must:

1. occur within 365 days of the *Accident*; and
2. be the direct and sole result of the *Accident*; and
3. be independent of disease or bodily infirmity.

The total amount of benefits payable for all losses above, for any *Covered Person* resulting from any one *Accident,* will not be greater than the *Principal Sum* set forth in the Schedule of Benefits.

Except as provided in a particular benefit provision, *We* will pay benefits for Loss of Life to the beneficiary(ies) named except as provided in a particular benefit provision. Benefits for all other *Losses* will be paid to *You*.

B. Coverage Plans Available

Individual Plan: If *You* enroll in the *Individual Plan, You* may select a *Principal Sum* within the range set forth in the Schedule of Benefits. *You* will be covered for the amount selected while coverage remains in force, subject to any adjustments resulting from an increase in age.

Family Plan: If *You* enroll in the *Family Plan*, *You* may select a *Principal Sum* within the range shown on the Schedule of Benefits. *Your Eligible Dependents* will be covered as shown on the Schedule of Benefits, subject to any adjustments resulting from an increase in age.

C. Eligibility Waiting Period

You must complete the Eligibility Waiting Period before becoming eligible for coverage. The Eligibility Waiting Period is determined by the *Policyholder* and reflects the amount of time *You* must be working for the *Policyholder* before becoming eligible for benefits. The requirements for eligibility are shown in the Schedule of Benefits.

D. Premium Contribution

If *Your* plan is Contributory, *You* pay all or a portion of the premium for *Your* insurance coverage. If *Your* plan is Noncontributory, the *Policyholder* pays 100% of the premium for your insurance. The premium contribution is shown in the Schedule of Benefits.

E. Premium

We allow a 60 day grace period for payment of every premium after the first premium payment. Data regarding the trend of premium increases or decreases for comparable policies issued by *Us* during the past five years is not available.

The average monthly premium rate for this product is between $2 - $5 per month per person.

Premiums may change on a periodic basis. Some factors which may cause a change in premium include the group's experience, a change in the group's participation, a change in the composition of the group, a change in the group's benefit design or a change in *Your* benefit amount.

F. Limitations and Exclusions

Limitations:

We will not pay any benefit for *Loss* resulting from or caused by:

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or
2. any heart, coronary or circulatory malfunction; or
3. any infection, except a pus-forming infection of an *Accidental* cut or wound; or
4. attempted suicide, regardless of mental capacity; or
5. any intentionally self-inflicted *Injury*; or
6. war, declared or undeclared, whether or not a member of any armed forces; or
7. travel or flight in any aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; excluding losses while on State business and in an aircraft owned by the State of Montana; or
8. commission of, participation in, or an attempt to commit an assault or felony under a state or federal law; or
9. The *Covered Person* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a licensed *Doctor* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
10. The *Covered Person* being intoxicated as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or
11. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

Exclusions:

We will not pay any benefits for death or dismemberment if the death or dismemberment occurred while *You* were operating a motor vehicle and *You* were either:

1. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by a licensed *Doctor* and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or
2. intoxicated as defined by the laws of the jurisdiction in which the death or dismemberment occurred or .08% blood alcohol content if such jurisdiction does not define intoxication. Conviction is not necessary for a determination of being intoxicated.

G. Termination of Coverage

Your coverage will terminate on the earliest of the following dates. Termination will not affect *Your* claim for a covered Loss which occurred while the coverage was in force.

1. the date on which the *Policy* is terminated; or
2. the first of the month following the date *You* stop making any required contribution toward payment of premiums; or if *You* were hired prior to August 1, 1998 and remained continuously covered by the State Plan, the last day of the calendar month next following the date the last period ends for which a premium contribution was made;
3. the effective date of an amendment to the *Policy* which terminates insurance for the class to which *You* belong; or
4. the first of the month following the date *You*
   a. are no longer a member of a class eligible for this insurance; or , if You were hired prior to August 1, 1998, the last day of the calendar month next following the date *You* are no longer a member of an eligible class,
   b. request termination of coverage under the *Policy;* or
   c. are retired or pensioned; or
   d. are no longer *Actively at Work* as a result of Temporary Layoff or Reduction in Force, *You* may continue to be eligiblefor group insurance coverage, until the end of the sixth month during which the temporary layoff or reduction in force began, provided all premiumsare paid when due, the *Policy* is in force, and *Your* coverage is not replaced with group accidental death and dismemberment insurance provided by another carrier.
5. For term-limited Legislators, coverage terminates the first of the month following 6 months from the last day of the term in office.
6. For a period of time the *Policyholder* agreed to continue coverage, provided all premiums are paid when due.

For the purposes of this provision, ***Disability*** means *You* are unable to perform all of the *Material and Substantial Duties* of *Your Regular Occupation*.

Dearborn Life Insurance Company

To be distributed to Canadian Resident Employees Only

As part of this insurance benefit, State of Montana has arranged for Dearborn Life Insurance Company to offer to you the benefits described in this Group Certificate, which may include certain conversion/portability/waiver of premium options. Please refer to the Certificate for more detail on these options and others.

This Group Certificate is issued under a Policy purchased by State of Montana. Dearborn Life Insurance Company is an Illinois domiciled insurance company and the Policy and this Group Certificate have been issued as part of its business in the United States. Dearborn Life Insurance Company is not regulated in Canada. Any disputes under the Policy or Group Certificate are to be resolved in a jurisdiction in the United States and in accordance with the provisions of the Policy and Group Certificate.

701 E. 22nd Street, Lombard, IL 60148 ▲ Toll Free: 800.721.7987 ▲ Fax: 630.824.5419

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

This notice provides a brief summary of the Montana Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders.

The Association was established under Montana law to provide protection in the unlikely event that a life, annuity or health insurance issuer becomes financially unable to meet its obligations and is placed into liquidation. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Montana law, with funding from assessments paid by other insurance companies.

In the event a company is placed into liquidation, benefits provided by the Association are payable according to the insurance policy or certificate, and subject to the following maximum limits:

Life Insurance

- $300,000 in death benefits, but limited to $100,000 in cash surrender and net cash withdrawal values.

Health Insurance

- $500,000 health insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 present value, including net cash surrender and net cash withdrawal values

The maximum amount of protection is $300,000 in benefits with respect to any one life regardless of the number of policies or contracts, except with respect to the $500,000 maximum in health insurance benefits but not including disability, long term care or other types of health insurance benefits.

Note: Other restrictions to coverage apply. Certain policies and contracts may not be covered or fully covered.

For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Montana law.

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

Montana Life and Health Insurance
Guaranty Association
PO Box 8247
Missoula, MT 59807
877-678-1048 or
administrator@mtlifega.org

Office of the Montana State Auditor
Commissioner of Securities and Insurance
840 Helena Ave.
Helena, MT 59601
406-444-2040

IF YOUR INSURANCE COMPANY IS IN GOOD STANDING AND NOT IN LIQUIDATION, PLEASE DIRECT QUESTIONS ABOUT YOUR POLICY TO YOUR INSURANCE COMPANY!

Insurance companies and agents are not allowed by Montana law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage.

If there is any inconsistency between this notice and Montana law, then Montana law will control.

END OF CERTIFICATE

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148