BlueCross BlueShield of Montana

Voluntary Long Term Disability Insurance

Employee Benefit Booklet

STATE OF MONTANA

F026969-0001

Class 1-01

11/24/2021

Group Certificate

Dearborn Life Insurance Company

Chicago, Illinois

Administrative Office:

701 E. 22nd Street

Lombard, IL 60148

Having issued Group Policy No. F026969

(herein called the Policy or this Plan)

to

State of Montana

(herein called the Policyholder)

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

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

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

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

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

Voluntary Group Long Term Disability Certificate

Non-Participating

2-LTDC-0119 MT 0821

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

Policyholder:	STATE OF MONTANA
Policy Number:	F026969-0001
Effective Date:	January 1, 2022

Eligibility:
Class 01

All active *Members* enrolled in the State sponsored health plan working for the *Policyholder* in the United States of America who are *Actively at Work* for the *Policyholder* and who have completed the *Waiting Period*.

Member means:
One of the following who is enrolled in the employer-sponsored health plan for employees of the State of Montana:

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 the Montana State Fund

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

Waiting Period:

Current *Members*: None
New *Members*: None. *You* are eligible on the date *You* become a *Member*.

Elimination Period: 180 Days

LTD Monthly Benefit: 60% of *Monthly Earnings* to a *Maximum Gross Monthly Benefit* of $9,200 per month subject to reduction by deductible sources of income or *Disability Earnings*.

Social Security Offset Method: Family Social Security

Minimum Monthly Benefit: $100 or 10% of *Your Gross LTD Monthly Benefit*, whichever is greater

Policyholder Contribution: 0% of premium

***Member* Contribution:** 100% of premium. *Member* contributions are not included in Employee's taxable income

Maximum Period Payable:

	Maximum Period Payable
	To Social Security Normal Retirement Age (SSNRA)
60	To Social Security Normal Retirement Age (SSNRA)
61	48 months or to SSNRA, whichever is greater
62	42 months or to SSNRA, whichever is greater
63	36 months or to SSNRA, whichever is greater

64	30 months or to SSNRA, whichever is greater
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

OTHER FEATURES

The following other features are included:

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

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

ELIGIBILITY AND EFFECTIVE DATES

Who is eligible for this insurance?

All active *Members* enrolled in the State sponsored health plan, excluding Legislators, working for the *Policyholder* in the United States of America who are *Actively at Work* for the *Policyholder* and who have completed the *Waiting Period*.

Member means:

One of the following who is enrolled in the employer-sponsored health plan for employees of the State of Montana:

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 the Montana State Fund

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

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

When does Your Contributory insurance become effective?

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

1. If there is no *Waiting Period*, the date *You* are eligible for coverage, if *You* enroll for coverage or sign the *Enrollment Form* 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 date *You* sign the *Enrollment Form*.
4. If *You* sign the *Enrollment Form* following this 31-day period, *You* are considered a late applicant and must furnish *Evidence of Insurability* satisfactory to *Us* before coverage can become effective. Coverage will become effective onthe date *We* determine that the *Evidence of Insurability* is satisfactory, and *We* provide written notice of approval.

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

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

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

When is Evidence of Insurability required?

Evidence of Insurability is required if:

1. *You* are a late applicant, which means *You* enroll for insurance more than 31 days after the date *You* are eligible for insurance; or
2. *You* voluntarily canceled *Your* insurance and are reapplying;

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

Changes to Your coverage

A change in *Your* coverage may occur if there is a Policy change.

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

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

1. The date *You* enroll for the additional coverage;
2. The date *We* approve *Your* coverage if *Evidence of Insurability* is required.

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

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

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

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

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

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.

Do You have to pay premium while You receive benefits?

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

What happens if We are replacing an existing Policy? (Continuity of Coverage)

Effect on Actively at Work requirement

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

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

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

Effect on Benefits

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

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

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

Effect on Pre-existing Conditions

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

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

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

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

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

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

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

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

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

Eligibility after Your Coverage Ends

If *Your* coverage ends due to termination of employment or because *You* cease to be a member of a class eligible for this insurance, *You* must meet all the requirements of a new *Member* if *You* are rehired or resume work as a member of a class eligible for this insurance at a later date.

Exception: If *Your* coverage ends due to termination of employment and you return to *Active Work* in an eligible classwithin 90 days, we will not:

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

Exception: If *Your* coverage ends because *You* cease to be a member of a class eligible for this insurance, without termination of employment, and you return to *Active Work* in an eligible class within 90 days, we will not:

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

LONG TERM DISABILITY BENEFITS

How do We define Total Disability?

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

1. *You* are continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*, and
2. *Your Disability Earnings,* if any, are less than 20% of *Your* pre-disability *Indexed Monthly Earnings*.

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

1. *You* are continuously unable to engage in any *Gainful Occupation,* and
2. *Your* Disability Earnings, if any, are less than 20% of Your pre-disability Indexed Monthly Earnings.

How do We define Partial Disability?

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

1. During the *Elimination Period You* are unable to perform all of the *Material* and *Substantial Duties* of *Your Regular Occupation*, and *You* are not working in any occupation.
2. During the first 24 consecutive months of benefit payments, due to *Injury* or *Sickness You* are unable to perform one or more 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 *Indexed Monthly Earnings*.
3. After the *LTD Monthly Benefit* has been paid for 24 consecutive months, *Partial Disability* or *Partially Disabled* means that due to *Injury* or *Sickness, You* are unable to engage in any *Gainful Occupation;* and *Your Disability Earnings,* if any, are at least 20% but less than or equal to 60% of *Your* pre-disability *Indexed Monthly Earnings*.

Loss of Professional License or Certification

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

What is the Elimination Period and how is it satisfied?

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

If *You* temporarily recover and return to work, *We* will treat *Your Disability* as continuous if *You* return to work for a period of less than or equal to one-half the *Elimination Period* rounded up to the next whole number, not to exceed 30 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 30 days, whichever is less, and become

Disabled again, *You* will have to begin a new *Elimination Period*.

Can You satisfy Your Elimination Period if You are working?

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

What Disability Benefit are You eligible to receive?

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

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

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

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

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

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

1. Multiply *Your Monthly Earnings* by 60%
2. The maximum *Gross LTD Monthly Benefit* is $9,200.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross LTD Monthly Benefit.*
4. Subtract the Deductible Sources of Income from *Your Gross LTD Monthly Benefit*. The resulting figure is *Your Net LTD Monthly Benefit*.
5. Compare the answer from item 3 and 4.

   The lesser amount figured in item 5 is *Your Monthly Benefit*.

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

What are the Deductible Sources of Income?

1. *Disability* benefits paid, payable, or for which *You* are eligible:
   a. The Social Security Act, including any amounts for which *Your* dependents may qualify because of *Your Disability*;
   b. Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
   c. Occupational accident coverage provided by or through the *Policyholder*;
   d. Any Statutory Disability Benefit Law;
   e. The Railroad Retirement Act;
   f. The Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act;
   g. The Canada Old Age Security Act;
   h. Any Public Employee Retirement System Plan, or any State Teachers' Retirement System Plan, or any plan provided as an alternative to any of the above acts or plans;
   i. Title 46, United States Code Section 688 et seq (The Jones Act);
   j. Title 33, United States Code Section 901 et seq (Longshore and Harbor Workers' Compensation Act).
2. *Disability* benefits paid, payable or for which *You* are eligible under:
   a. Any group insurance plan , and
   b. Any sick leave, paid time off, or salary continuance plan provided by or through the *Policyholder* which causes the *Net Monthly Benefit*, plus Deductible Sources of Income and any salary continuation to exceed 100% of *Your* pre-disability *Indexed Monthly Earnings*. The amount in excess of 100% of *Your* pre-disability *Indexed Monthly Earnings* will be used to reduce *Your Net Monthly Benefit*.
   c. Any federal, state or local paid family medical leave or similar plan which causes the *Net Monthly Benefit*, plus Deductible Sources of Income and any salary continuation to exceed 100% of *Your* pre-

disability *Indexed Monthly Earnings*. The amount in excess of 100% of *Your* pre-disability *Indexed Monthly Earnings* will be used to reduce *YourNet Monthly Benefit*.

3. Retirement benefits paid under the Social Security Act including any amounts for which Your dependents may qualify because of Your retirement;
4. Retirement and *Disability* benefits paid under a *Retirement Plan* provided by the *Policyholder* except for amounts attributable to *Your* contributions;
5. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;
6. Amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the net settlement;
7. Any unemployment benefits *You* are eligible to receive.

Proration of Lump Sum Awards

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

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

What other sources of income are not deductible?

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

1. deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2. credit disability insurance;
3. pension plans for partners;
4. military pension and disability income plans;
5. franchise disability income plans;
6. individual disability income plans;
7. a *Retirement Plan* from another *Policyholder*;
8. profit sharing plans;
9. thrift or savings plans;
10. individual retirement account (IRA);
11. tax sheltered annuity (TSA);
12. stock ownership plan.

Can You work and still receive benefits?

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

Work Incentive Benefit

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

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

1. *We* will add together the *Gross Monthly Benefit* and *Disability Earnings* and compare to pre-disability *Indexed Monthly Earnings*.

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

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

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

1. the date *You* are no longer *Disabled;* or
2. the end of the *Maximum Period Payable*; or
3. after the Work Incentive Benefit has been paid for 12 months.

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

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

B= *Your pre-disability Indexed Monthly Earnings*

Rehabilitation Incentive Income

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

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

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

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

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

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

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

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

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

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

The *Net LTD Monthly Benefit* payable for *Disability* will not be less than $100 or 10% of *Your Gross LTD Monthly Benefit,* whichever is greater. The minimum *Net LTD Monthly Benefit* does not apply if *You* are *Gainfully Employed*.

What happens if Your Deductible Sources of Income increase?

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

How long will You receive benefits under the Policy?

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

What happens if Your Disability recurs?

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

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

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

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

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

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

- loss of professional license, occupational license or certification.
- a *Pre-Existing Condition* ;
- Intentionally self-inflicted injuries;
- attempted suicide, regardless of mental capacity;
- participation in a war, declared or undeclared, or any act of war;
- active military duty;
- active *Participation in a Riot*;
- commission of a crime for which *You* have been convicted;
- occupational *Sickness* or *Injury*.

The *Policy* has limitations on:

- *Mental Disorder* - *Disability* beyond 24 months after the *Elimination Period* if it is due to a *Mental Disorder* of any type. Confinement in a *Hospital* or institution licensed to provide care and treatment for mental illness will not be counted as part of the 24 month limit.

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

1. 24 *LTD Monthly Benefit* payments have been made for a *Disability* due to a *Mental Disorder*; or
2. the *Maximum Period Payable* is reached; or
3. *You* refuse to participate in an appropriate, available treatment program, or *You* leave the treatment program prior to completion; or
4. *You* are no longer following the requirements of *Your* treatment plan under the program; or
5. *You* complete the initial treatment plan, exclusive of any aftercare or follow-up services.

The lifetime cumulative *Maximum Period Payable* for all disabilities due to a *Mental Disorder*, is 24 months. Only 24 months of benefits will be paid even if the disabilities:

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

Furthermore:

- Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
- Benefits are not payable if *Your Disability Earnings* exceed 80% of *Your* pre-disability *Indexed Monthly Earnings*.
- Benefits are not payable during the first 24 months of *LTD Monthly Benefits*, when *You* are able to return to work in *Your Regular Occupation* on a part-time basis but *You* do not.
- Benefits are not payable after 24 months of *LTD Monthly Benefits*, when *You* are able to work in any *Gainful Occupation* on a part-time basis but *You* do not.
- Benefits will not be payable if the *Policyholder* is willing to make reasonable accommodations to allow *You* to return to *Your Regular Occupation* with a loss of income no greater than 20% of pre-disability *Indexed Monthly Earnings*, and *You* refuse to return to work.

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 first of the month following the date *You* stop making any required contribution toward payment of premiums;
3. the date on which the Employer's participation under the Policy is terminated; or
4. the first of the month following 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* or *Layoff* unless *We* and the *Policyholder* have agreed in writing in advance of the leaveto continue insurance during such period.

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

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 or local 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 FMLA; or
2. the leave period permitted by applicable state or local law.

While granted FMLA or State FML 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*.

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

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

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

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

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

CLAIMS SERVICES

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

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

Vocational Rehabilitation Service

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

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

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

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

Social Security Disability Assistance

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

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Written Proof of Loss

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

Time Limit for Filing *Your* Claim

You must furnish *Us* with written proof of loss within 6 months of the *Date of Disability*. If it is not possible to give *Us* written proof within 6 months of the *Date of Disability*, 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. Ho*we*ver, *You* can request that benefits be paid for late claims if *You* can show that:

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

Proof of *Disability*

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

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

Continuing Proof of *Disability*

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

Examination

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

Authorization and Documentation *You* will be asked to supply

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

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *We* will pay *Your* benefit on a monthly basis, so long as *You* continue to qualify for it.

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: *Your:* 1) spouse; 2) children including legally adopted children; 3) parents; or 4) *Your* estate.

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

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 of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment madeby *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 Monthly Benefit*.

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

Subrogation Right of Reimbursement

To the extent necessary for reimbursement of benefits paid to *You*, *We* are entitled to subrogation against a judgment or recoveryreceived by *You* from a third party found liable for a wrongful act or omission that caused the *Injury* necessitating benefit payments.

If *You* intend to institute an action for damages against a third party, *You* must give *Us* reasonable notice of the intent to institute the action. *You* may request that *We* pay a proportionate share of the reasonable costs of the third party action, including attorneyfees. If *We e*lect not to participate in the cost of the action, *We* waive 50% of any subrogation rights. *Our* right of subrogation will be enforced only after *You* have been fully compensated for the I*njury*.

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the *Policyholder*'s application, the *Member*'s certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract bet*we*en the parties. Coverage under the Policy can be amended by mutual consent betwe*e*n 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 *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*.

Legal Actions

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

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

Clerical Error

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

1. Prevent *You* from receiving coverage, if *You* are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for *You* when the coverage would not otherwise be effective. If the *Policyholder* gives *Us* information about *You* that is incorrect, *We* will:
    1. Use the facts to decide whether *You* have coverage under the Policy and in what amounts; and
    2. Make a fair adjustment of the premium.

Misstatement of Age

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

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

Incontestability

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

Conformity with State Statutes and Regulations

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 Covered Person resides on or after the Effective Date of this Certificate.

Workers' Compensation or State Disability Insurance

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

Agency

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

General Provisions

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

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

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

DEFINITIONS

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

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

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

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).

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

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*.

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

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

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

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

Domestic Partner or ***Registered 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 *Domestic Partner* other than shown above, that definition will be used in the Policy.

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

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

Gainful Occupation, Gainful Employment or ***Gainfully Employed*** means the performance of any occupation within the national economy, for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, and in which you earn, or could be reasonably expected to earn, 60% or more of *Your* pre- disability *Indexed Monthly Earnings*.

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

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

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

Indexed Monthly Earnings means *Your Monthly Earnings* adjusted on each anniversary of benefit payment by the lesser of 7% or the current annual percentage increase in the *Consumer Price Index*. *Your Indexed Monthly Earnings* may increase or remain the same, but will never decrease.

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

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

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*.

Layoff means *You* are temporarily not *Actively at Work*, due to suspension of work hours, at written the instruction of *Your* Employer. *Layoff* does not include permanent suspension of work hours, or termination of employment.

LTD means Long Term Disability.

Male pronoun, whenever used, includes the female.

Material and Substantial Duties means duties that:

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

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

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

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

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

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

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

Monthly Earnings will be based on *Your* income from the *Policyholder* in effect on your last full day of Active Work. Any subsequent change in your earnings after that last full day of Active Work will not affect your *Monthly Earnings*.

Monthly Earnings means your monthly rate of earnings from your Employer, including:

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.
2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Monthly Earnings does not include:

a. Bonuses.

b. Commissions.

c. Overtime pay.

d. Shift differential pay.

e. *Your* Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.

f. Any other extra compensation.

If *You* are paid on an annual contract basis, *Your* monthly rate of earnings is one-twelfth (1/12th) of *Your* annual contract salary.

If *You* are paid hourly, *Your* monthly rate of earnings is based on *Your* hourly pay rate multiplied by the number of hours *You* are regularly scheduled to work per month, but not more than 173 hours. If *You* do not have regular work hours, *Your* monthly rate of earnings is based on the average number of hours *You* worked per month during the preceding 12 calendar months (or during *Your* period of employment if less than 12 months), but not more than 173 hours.

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

Participation in a Riot shall include promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but shall not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firemen.

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 or recommended within 6 months prior to *Your* effective date; and
2. is not covered for the first 12 months after *Your* effective date.

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

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

Retirement Plan means a plan which provides retirement benefits to *Members* and is not funded wholly by *Member* contributions.

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

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

Sickness means illness or disease, including pregnancy, causing *Disability* which begins while *You* are covered under the Policy.

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

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*.

We, ***Our*** and ***Us*** mean the 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.

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

DEARBORN LIFE INSURANCE COMPANY
Chicago, Illinois

AMENDATORY RIDER

This Amendment, effective January 1, 2022, is part of the Policy or Certificate to which it is attached. It is subject to all provisions of the Certificate not in conflict with the provisions of this Amendment.

The *When will Your Insurance Terminate* provision is amended to read:

Your insurance may continue after the date it would have otherwise ended because *You* ceased to be a *Member*, subject to the following:

1. During the first 90 days of a temporary or indefinite administrative or involuntary leave of absence, provided *Your Employer* is paying *You* at least the same *Pre-disability Earnings* paid to *You* immediately before *You* ceased to be a *Member*. A period when *You* are absent from *Active Work* as part of a severance or other employment termination agreement is not a leave of absence, even if *You* are receiving the same *Pre-disability Earnings*. *Your* insurance will terminate if *You* are not a *Member* immediately following the 90 day leave period.
2. During the first 6 months of a temporary layoff. *Your* insurance will terminate if *You* are not a *Member* immediately following the 6 month leave.
3. During a leave of absence if your insurance is continued under the *Self Pay Provision*. See the *Self Pay Provision* for more information.

SELF PAY PROVISION
You may continue *Your* insurance during the periods below by paying the entire cost of *Your* insurance to the *Employer* on or before each premium due date. *You* must elect to continue *Your* insurance on or before the date *Your* insurance would otherwise end, and *You* may not become insured again after *Your* insurance ends unless *You* return to *Active Work*.

- For up to 18 months while *You* are on approved leave without pay status, if *You* are a represented *Member*.
- For up to 12 months while *You* are on approved leave without pay status, if *You* are any *Member* other than a represented *Member.*
- For up to 12 months while *You* are receiving *Worker's Compensation* benefits for any *Sickness* or *Injury* sustained during state employment.

Nothing contained in this Amendment shall be held to alter or affect any provision or condition of your coverage other than as stated above.

President

Administrative Office:

701 E. 22nd Street Lombard IL, 60148

DEARBORN LIFE INSURANCE COMPANY
Chicago, Illinois

WORKSITE MODIFICATION BENEFIT AMENDATORY RIDER

This Rider, effective January 1, 2022, is part of the Policy or Certificate to which it is attached. It is subject to all provisions of the Policy or Certificate not in conflict with the provisions of this Rider.

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. $25,000; or
2. 2 times *Your Last Monthly Benefit.*

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

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

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

Additionally, *We* may assist *You* and an employer, other than the *Policyholder*, in identifying modifications *We* agree are likely to help *You* return to work. This agreement will be in writing and must be signed by *You*, the employer making the modification and *Us*.

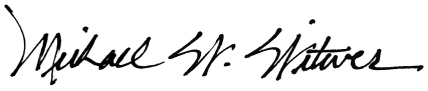
When this occurs, *We* will reimburse the employer for the cost of the modification, up to the greater of:

1. $25,000; or
2. 2 times Your Last Monthly Benefit.

We will reimburse the employer upon completion of the following:

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

Nothing contained in this Rider shall be held to alter or affect any provision or condition of your coverage other than as stated above.



President

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

DEARBORN LIFE INSURANCE COMPANY
Chicago, Illinois

SURVIVOR INCOME BENEFIT AMENDATORY RIDER

This Rider, effective January 1, 2022, is part of the Policy or Certificate to which it is attached. It is subject to all provisions ofthe Policy or Certificate not in conflict with the provisions of this Rider.

What happens if You die while receiving benefits?

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

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

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

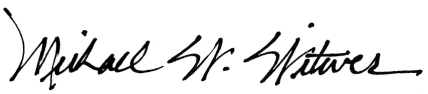
Eligible Survivor means *Your* Spouse, if living, or if *Your Spouse* dies before the final monthly benefit is paid, then *Your* children who are under age 25.
If payment becomes due to *Your* children, payment will be made to:

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

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

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

Nothing contained in this Rider shall be held to alter or affect any provision or condition of your coverage other than as stated above.



President

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 Insurance840 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.

GEN-55-1019

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

END OF CERTIFICATE

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148