BlueCross BlueShield of Oklahoma

Voluntary Short Term Disability Insurance

Employee Benefit Booklet

CITY OF TULSA

F024608-0001

LOW PLAN

01/03/2020

Dearborn Life Insurance Company

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

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

Having issued Group Policy No. F024608-0001

(herein called the Policy)

to

CITY OF TULSA

(herein called the Policyholder)

Group Insurance Certificate

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

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

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

READ YOUR CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary

President

Voluntary Group Short Term Disability Insurance Certificate

Non-Participating

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

SHORT TERM DISABILITY BENEFITS

EXCLUSIONS AND LIMITATIONS

TERMINATION OF COVERAGE

SUPPLEMENTAL BENEFITS

- WORKSITE MODIFICATION BENEFIT
- SURVIVOR INCOME BENEFIT

FILING A CLAIM

UNIFORM PROVISIONS

DEFINITIONS

SCHEDULE OF BENEFITS

Policyholder:	CITY OF TULSA
Policy Number:	F024608-0001
Effective Date:	January 1, 2020
Annual Enrollment Period:	October 1 to November 30
Eligibility: **Low Plan**	All Active full-time Non-Sworn Employees electing the Low Plan of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time Employee is one who regularly works a minimum of 30 hours per week for the Policyholder. Part-time, seasonal and temporary Employees of the Policyholder are not eligible.
Eligibility Waiting Period:	**Current Employees** If You are in a class eligible for insurance on or before the Policy Effective Date: First of the month following 30 Days of continuous, full-time Active work **New Employees** If You enter a class eligible for insurance after the Policy Effective Date: First of the month following 30 Days of continuous, full-time Active work

Short Term Disability

STD Benefit Percentage	40% of Your Weekly Earnings, not to exceed $750.00
Maximum STD Weekly Benefit	$750.00
Minimum STD Weekly Benefit	$25.00
Elimination Period	7 Days - Injury 7 Days - Sickness
Benefits are Payable on	Day 8 of Injury Day 8 of Sickness;
Maximum Period Payable	26 Weeks following the Elimination Period
Benefits are Payable for	Non-occupational disabilities only
Policyholder Contribution	0% of Premium

OTHER FEATURES

- Work Incentive Benefit
- Recurrent Disability
- Worksite Modification
- Survivor Benefit
- FMLA Coverage Extension

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

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

All Active full-time Non-Sworn Employees electing the Low Plan of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Waiting Period are eligible for the insurance. A full-time Employee is one who regularly works a minimum of 30 hours per week for the Policyholder. Part-time, seasonal and temporary Employees of the Policyholder are not eligible.

The Waiting Period is shown in the Schedule of Benefits.

When does Your Contributory insurance become effective?

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

1. If there is no Waiting Period, the date You are eligible for coverage, if You enroll for coverage on or before that date;
2. If You sign the Enrollment Form during the Waiting Period, the date You are eligible for coverage;
3. If You sign the Enrollment Form after the end of the Waiting Period, but within 31 days after that day, Your coverage will become effective on the first of the month that falls on or next follows the date You sign the Enrollment Form;
4. If You do not sign the Enrollment Form within this 31-day period, You must wait until the next Annual Enrollment to apply for coverage, unless You qualify because of a Change in Family Status.
    a. Initial requests for coverage or requests for changes to existing coverage made during the Annual Enrollment period will become effective on the Policy anniversary date.
    b. Coverage because of a Change in Family Status will become effective on the first of the month that falls on or next follows the date You sign the Enrollment Form.

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

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

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

Change in Family Status

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

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

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

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

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

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

What is an Annual Enrollment period?

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

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

Initial requests for coverage or requests for changes to existing coverage made during the Annual Enrollment period will become effective on the Policy anniversary date.

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

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

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

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

Changes to Your coverage

A change in Your coverage may occur if:

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

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

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

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

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

Any decrease in coverage will take effect immediately.

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

Who pays for Your coverage?

You pay the entire cost of Your coverage.

What happens if We are replacing an existing Policy?

Effect on Actively at Work requirement

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

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

2. The end of any period of continuance or extension provided under the Prior Policy; or
3. The date coverage would otherwise end, according to the provisions of the Policy.

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

Effect on Benefits

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

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

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

Effect on Pre-existing Conditions

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

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

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

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

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

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

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

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

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

Eligibility after You Terminate Employment

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

Exception: If Your coverage ends due to termination of employment and you return to Active Work in an eligible class within 30 days, we will not:

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

SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or **Disabled** means that You satisfy the definition of Total Disability or Partial Disability and You are receiving Appropriate and Regular Care for Your condition from a Doctor.

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

How do We define Total Disability?

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

How do We define Partial Disability?

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

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

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

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 14 days. The days that You are not Disabled will not count toward Your Elimination Period.

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

Can You satisfy Your Elimination Period if You are working?

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

What Disability Benefit are You eligible to receive?

If You are Disabled and receiving Appropriate and Regular Care for Your condition from a Doctor, You are eligible to receive one of the following at any given time:

1. an STD Weekly Benefit; or
2. a Work Incentive Benefit.

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

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

Your STD Weekly Benefit will be based on Your Weekly Earnings as reported to Us by Your Employer and for which premium has been paid.

An STD Weekly Benefit will be payable after the end of the Elimination Period if You are Disabled.

We will calculate Your Gross STD Weekly Benefit amount as follows:

1. Multiply Your Weekly Earnings by the STD Benefit Percentage, shown on the Schedule of Benefits.
2. The maximum STD Weekly Benefit as shown on the Schedule of Benefits.
3. Compare the answers from Item 1 and Item 2. The lesser of these two amounts is Your Gross STD Weekly Benefit.
4. Subtract the Deductible Sources of Income from Your Gross STD Weekly Benefit. The resulting figure is Your Net STD Weekly Benefit.

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

If You are receiving any compensation from Your Employer, including, but not limited to:

1. Salary Continuation;
2. sick leave benefits; or
3. vacation pay,

We will not begin STD Weekly Benefit payments until such compensation payments cease.

Can You work and still receive benefits?

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

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

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

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

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

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

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

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

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

What are the Deductible Sources of Income?

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

1. Disability benefits paid, payable or for which You are eligible under:
    a. any state compulsory disability benefit Act or Law.
    b. any group insurance plan provided by or through the Policyholder.
    c. any State Teachers Retirement System, Public Employees Retirement System or School Employees Retirement System.
    d. the Social Security Act, including any amounts for which Your dependents may qualify because of Your Disability.
    e. the Canada Pension Plan, Quebec Pension Plan, or any other similar disability or pension plan or act.
    f. the Canada Old Age Security Act.
    g. any Workers' Compensation or Occupational Disease Act or Law, or any other Law which provides compensation for an occupational Injury or Sickness.

    Denial of Workers' Compensation will not result in the payment of benefits under the Policy if Your Disability resulted from an occupational Sickness or Injury. Benefits are also not payable under the Policy if You are entitled to participate in Workers' Compensation and choose not to do so.
2. Retirement benefits paid under the Social Security Act including any amounts for which Your dependents may qualify because of Your retirement;
3. Retirement and Disability benefits paid under a Retirement Plan provided by the Policyholder except for amounts attributable to Your contributions;
4. Disability benefits paid under any No Fault Auto Motor Vehicle coverage;
5. Amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the net settlement.

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

Proration of Lump Sum Awards

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

1. We will divide the amount paid by the number of weeks for which the settlement or advance was provided; or
2. If the number of weeks for which the settlement or advance is made is not known, We will divide the amount of the settlement or advance by the expected remaining number of weeks for which We will provide benefits for Your Disability based on the Proof of Disability which We have, subject to a maximum of 26 weeks.

What other sources of income are not deductible?

We will not reduce Your Gross STD Weekly Benefit under the Policy by any of the following:

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

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

The Net STD Weekly Benefit payable for Disability will not be less than $25.00. The minimum Net STD Weekly Benefit does not apply if You are Gainfully Employed.

What happens if Your Deductible Sources of Income increase?

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

How long will You receive benefits under the Policy?

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

What happens if Your Disability recurs?

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

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

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

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

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Policy?

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

1. loss of professional license, occupational license or certification.
2. a Pre-existing Condition;
3. commission of, participation in, or an attempt to commit an assault or felony;
4. Intentionally self-inflicted injuries;
5. attempted suicide, regardless of mental capacity;
6. Cosmetic Surgery except when required due to Injury or Sickness;
7. Occupational Injury or Sickness;
8. war or acts of war, declared or undeclared, when serving in the military or an auxiliary unit thereto.

Furthermore:

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

TERMINATION OF COVERAGE

When will Your insurance terminate?

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

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

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

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

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

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

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

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

While granted a Family or Medical Leave of Absence:

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

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

We will not:

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

Will coverage be continued for other leaves of absence?

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

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

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

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

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

SUPPLEMENTAL BENEFITS

WORKSITE MODIFICATION BENEFIT

What is the Worksite Modification Benefit?

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

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

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

We will reimburse the Policyholder upon completion of the following:

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

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

SURVIVOR INCOME BENEFIT

What happens if You die while receiving benefits?

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

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

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

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

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

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

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

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

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

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

Telephonic Claim Notification

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

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 90 days after the end of Your Elimination Period. The length of the Elimination Period is shown in the Schedule of Benefits. If it is not possible to give Us written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless You are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

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

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

Proof of Disability

The following items, supplied at Your expense, must be a part of 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 Weekly Earnings.
8. If You were contributing to the premium cost, the Policyholder must supply proof of Your appropriate payroll deductions.
9. The name and address of any Hospital or health care facility where You have been treated for Your Disability.
10. If applicable, proof of incurred costs covered under other benefit provisions in the Policy.

Continuing Proof of Disability

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

Examination

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

Authorization and Documentation You will be asked to supply

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

Time of Payment of Claim

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

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

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

Can You assign Your benefits?

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

What will happen if a claim is overpaid?

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

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

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

We will not request a refund of all or a portion of an overpayment of benefits more than 24 months after the payment is made. The only exceptions to this are when the payment was made because of fraud committed by the claimant or health care provider, or if the claimant or health care provider has otherwise agreed to make a refund to Us for overpayment of a claim.

Subrogation - Right of Reimbursement

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

UNIFORM PROVISIONS

Entire Contract; Changes

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

Statements on the Application

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

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

Legal Actions

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

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

Clerical Error

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

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

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

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

Misstatement of Age

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

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

Incontestability

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

Conformity with State Statutes and Regulations

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

Workers' Compensation or State Disability Insurance

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospital means either of the following:

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

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

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

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

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

Male pronoun, whenever used, includes the female.

Material and Substantial Duties means duties that:

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

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

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

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

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

Pre-existing Condition means a condition which:

1. was caused by, or results from a Sickness or Injury for which You received medical treatment, or advice was rendered, prescribed or recommended whether or not the Sickness was diagnosed at all or was misdiagnosed within 3 months prior to Your effective date; and
2. results in a Disability which begins in the first 12 months after Your effective date.

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

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

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

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

Spouse means lawful Spouse.

STD means Short Term Disability.

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

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

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

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

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

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

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $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
  - $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: 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 Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

GEN-51-1019

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits

   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

   b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

   c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

   In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other plan participants and beneficiaries. No one, including Your employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

3. Enforce Your Rights

   If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

   Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

   If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions

   If You have any questions about Your Plan, You should contact the Plan Administrator. If You have questions about this statement or about rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, Washington, D.C. 20210. You may obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

ERISA INFORMATION STATEMENT

The benefits described in your certificate are insured by a Disability Insurance Policy ("Policy") issued by Blue Cross and Blue Shield of Oklahoma (“We” or "Insurer"), pursuant to an "employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1), established by your employer, or where applicable, employee organization (the “Policyholder").

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

A. ADMINISTRATION OF THE PLAN

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

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

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

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

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

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

B. CLAIMS PROCEDURE :

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

Claims Department

Blue Cross and Blue Shield of Oklahoma

701 E. 22nd Street

Lombard, IL. 60148

1-888-381-9727

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

Disability Insurance Plans

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

If the claim is denied, in whole or in part, We will provide You with a written notice giving the following:

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

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

You may:

a. request a review upon written application within 180 days of the claim denial;

b. request, free of charge, copies of all documents, records and other information relevant to your claim; and

c. submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after We receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, We notify you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date We receive your response to the request.

If the adverse benefit determination is upheld on administrative appeal, in whole or in part, We will provide You with a written notice giving the following:

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

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148