Group Dental Insurance

Employee Benefit Booklet

VIVA USA, INC.

F1D1358-0001

Class 1-01

05/03/2012

FORT DEARBORN LIFE
Insurance Company®

Group Dental Insurance Certificate

Fort Dearborn Life Insurance Company

Chicago, Illinois

Administrative Office:

1020 31st Street

Downers Grove, IL 60515

Fort Dearborn Life Insurance Company hereby certifies that it has issued a Group Dental Insurance Policy (herein called the "Plan") for the Employees of the Policyholder named on this Certificate. Subject to the provisions of the Plan, each Employee to whom a Fort Dearborn Life Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the effective date shown on the Schedule of Benefits, if the Policyholder makes timely payment of total premium due to FDL. Issuance of this Certificate by FDL does not waive the eligibility and effective date provisions stated in the Plan.

President

The Schedule of Benefits enclosed with this Certificate indicates benefit percentages, Deductibles, maximums, and other terms and conditions which apply to coverage under the **Plan**. The Schedule of Benefits specifies benefits for:

DENTAL BENEFITS

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SCHEDULE OF BENEFITS

Benefits described in this Certificate apply only if also listed here.

Policyholder:	VIVA USA, INC.
Policy Number:	F1D1358-0001
Effective Date:	May 1, 2012
Class:	All Eligible Employees
Employee and Dependent eligibility:	All Eligible Employees
Waiting Period:	30 days.
Dependent child age limit:	26
Predetermination amount:	$0
Deductible each Calendar Year for each Participant:	$100
Family deductible:	$300
Three-month deductible carryover:	NO

DENTAL BENEFITS

DENTAL EXPENSE BENEFIT	AMOUNT	
	IN-NETWORK	**OUT-OF-NETWORK**
Annual Deductible Amount		
Individual	$100	$100
Family	$300	$300
Note: Deductible waived for Preventive and Diagnostic Services and Miscellaneous Services. Covered dental expenses incurred toward the deductible amount apply to both the In-Network and Out-of-Network Plan.		
Benefit Categories	**Covered Percentage of Allowable Expenses**	
1. Diagnostic and Preventive Care	100%	100%
2. Miscellaneous Services	100%	100%
3. Restorative Services	80%	80%
4. General Services	80%	80%
5. Endodontic Services	50%	50%
6. Periodontal Services	50%	50%
7. Oral Surgery Services	50%	50%
8. Crowns, Inlays/Onlays Services	50%	50%
9. Prosthodontic Services	50%	50%

MAXIMUM CALENDAR YEAR BENEFITS		MAXIMUM LIFETIME BENEFITS	
Covered Dental Expenses (excluding Orthodontia)	$1,500	Implant Services	$0
Orthodontic Services	$0	Orthodontic Services	$0
Temporomandibular Joint (TMJ) Services	$0	Temporomandibular Joint (TMJ) Services	$0
Note: Amounts applied to the benefit maximums will apply to both the In-Network and Out-of-Network.			

INTRODUCTION

EXPLANATION

This Plan has been designed and selected by the Policyholder as one of the benefits of Your employment. Please read this Certificate carefully so You will be aware of the benefits and requirements of the Plan. This Certificate summarizes Plan benefits and provisions for Dental Benefits.

Benefits for Covered Dental Services described in this Certificate are determined by the benefit categories listed below. **You are covered only for those benefit categories selected by the Policyholder and shown on the Schedule of Benefits.** The benefit percentage to be applied to each benefit category is shown on the Schedule of Benefits.

- Diagnostic and Preventive Care Services
- Miscellaneous Services
- Restorative Services
- General Services
- Endodontic Services
- Periodontal Services
- Oral Surgery Services
- Crowns, Inlays/Onlays Services
- Prosthodontic Services

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

IDENTIFICATION CARD

You will be issued an Identification Card. This card identifies You and any covered family members as Participants in the FDL Dental Benefits Plan. Your card contains important information about You, the Policyholder, and the benefits to which You are entitled.

Always remember to carry Your Identification Card with You and present it to Your Dentist when receiving dental services or supplies. Dentists will use the information on Your card to file claims for You and any covered family members. Any time a change in Your family takes place, it may be necessary for a new Identification Card to be issued to You. Contact the Policyholder for more information. Upon receipt of the changed information, a new Identification Card will be issued and forwarded to the Policyholder for distribution to You.

WHO GETS BENEFITS

WHO IS ELIGIBLE FOR COVERAGE?

Employees and Retirees who are in a class named in the Application and their Dependents are eligible for coverage under the Plan. Only individuals who meet the following eligibility requirements may apply for coverage under the Plan.

Employee Eligibility

You are eligible for coverage under the Plan if You are an Employee in a class shown on the Schedule of Benefits and You have completed the waiting period, if any. You may apply for coverage for Yourself and Your Eligible Dependents on or before Your Eligibility Date.

Dependent Eligibility

For the purposes of this provision, an eligible Dependent includes:

1. an eligible Employee's lawful spouse, including a spouse or former spouse for whom the Employee has received a court order to maintain financial responsibility for providing health insurance; and/or
2. any unmarried child of an eligible Employee who is within the age limits set forth in the Schedule of Benefits, and is not in active military service, including:
    a. the Employee's natural child; or
    b. the Employee's legally adopted child;
    c. the Employee's stepchild; or
    d. a child for whom the Employee has received a court order to maintain financial responsibility for providing health insurance.

Eligibility will continue past the limiting age for eligible Dependent children who are primarily dependent upon the Employee for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request.

A person cannot be insured as an Employee and also as a Dependent under the Plan. If both the husband and the wife are covered as Employees under the Plan, only one may enroll for dental coverage on Dependent child (ren).

Retiree Eligibility

If you are a retired Employee and retired Employees are listed as an eligible class on the Application, You are eligible to continue Your coverage under the Plan, provided You were covered under the Plan as an Employee on the date of retirement. You may not enroll for dental coverage under the Plan at retirement.

Eligibility Date

The Eligibility Date is the date a person becomes eligible to be covered under the Plan, as follows:

1. For an Employee hired after the Policy Effective Date, the date the Employee completes the waiting period (i.e. the number of days of continuous employment required by the Policyholder for coverage under the Plan).
2. For an Employee hired prior to the Policy Effective Date, the Eligibility Date will be the Policy Effective Date. The waiting period will be waived unless indicated in the Application.
3. For a Dependent who meets the definition of an Eligible Dependent on the Employee's Eligibility Date, the Employee's Eligibility Date.
4. For a Dependent of an eligible Employee acquired while he is covered under the Plan, the date the Employee acquires the Dependent, as follows:
    a. the date of marriage,

b. the date of birth,

c. the date of placement for adoption;

d. the date of issuance of a court order requiring the Employee to maintain financial responsibility for health coverage for a Dependent spouse or child.

WHEN DOES COVERAGE BEGIN?

The effective date is the date coverage for a Participant actually begins. It may be different from the Eligibility Date.

Non-Contributory Coverage

Noncontributory benefits under the Plan will become effective for an Employee who is Actively at Work on the day following completion of the waiting period, if any, set forth in the Application.

Contributory Coverage

Contributory coverage will become effective as follows, provided the Employee is Actively at Work on that date:

1. If the enrollment form is signed on or before the end of the waiting period, if any, as stated in the Application, the coverage will become effective on the day following completion of the waiting period.

2. If the enrollment form is signed after the end of the waiting period, but within 31days after that day, the coverage will become effective the date the Employee signs the enrollment form.

Dependent Coverage

Covered Employees may add Dependent children at any time, up to age 5, and coverage will become effective on the first of the month following receipt by FDL of application and the required premium.

Coverage for a natural, step or adopted Dependent child who becomes eligible after the Employee's coverage effective date is automatically effective on the Dependent's Eligibility Date for 31 days. To continue coverage beyond the 31 day period, the Employee must submit application and any applicable premium within the 31 day period.

Covered Employees may add a newly acquired Dependent spouse, and if the application is received by FDL within 31 days of the Dependent's Eligibility Date, the coverage will become effective on the Dependent's Eligibility Date.

Deferred Effective Date

An Employee must be Actively at Work on the date his coverage under the Plan is scheduled to begin. If:

1. he is absent from Active Work on the date such coverage would otherwise become effective; and

2. his absence is caused by an injury, illness or layoff,

the effective date of coverage will be deferred until the first day he returns to Active Work. An Employee will be considered Actively at Work if he was actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);

2. a holiday (except when such holiday is a scheduled work day);

3. a paid vacation;

4. any nonscheduled work day.

ANNUAL ENROLLMENT

If You are eligible, and You do not enroll within the first 31 days of becoming eligible, You may enroll for dental insurance, apply for additional coverage, or request changes to Your current dental benefits only during Annual Enrollment.

REPORTING CHANGES IN YOUR FAMILY

You should notify the Policyholder promptly if any of the following events take place:

1. You marry or divorce,
2. A child is acquired, by marriage, new birth or adoption,
3. A child marries or reaches the age limit described below,
4. A Participant in Your family dies, or
5. You receive a court order to provide health coverage for Your child or spouse.

You should promptly notify FDL by filling out a form which has been furnished to the Policyholder. If You are adding a Dependent, You must submit an application and the coverage will become effective as described in the Dependent Coverage effective date provision above.

WHEN DOES COVERAGE END?

FDL is not required to give You notice of termination of coverage. FDL will not always know of the events causing termination until after the events have occurred.

Termination of Coverage

Insurance coverage will end for You on the earliest of:

1. the date You are no longer a member of a covered class; or
2. the date the Plan is canceled; or
3. the effective date of an amendment to this Plan which terminates insurance for the class to which You belong; or
4. the date You stop making any required contribution toward payment of premiums; or
5. the last day of the insurance month during which You are no longer Actively at Work; and
6. for Dependents, the date a Dependent child or spouse is no longer eligible for coverage as defined in this Certificate.

If coverage for a Dependent terminates because of loss of eligibility as listed above, coverage ends automatically and benefits for expenses incurred after termination are not available. If We pay benefits prior to our receiving notification of Your termination, We will request a refund. If Your coverage or that of Your Dependents ends, You may be eligible to continue coverage at Your own expense. Review carefully the **CONTINUATION OF COVERAGE RIGHTS UNDER COBRA** Notice at the back of this Certificate.

Termination of the Group

The coverage of all Participants will terminate in accordance with the terms of the Plan if the group is terminated.

LOSS OF ELIGIBILITY

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

HOW TO RECEIVE BENEFITS

DENTAL NETWORK OF AMERICA PPO DENTISTS

FDL has an arrangement with certain Preferred Providers (herein called Dental Network of America Dentists) to discount their charges for Covered Dental Services. You have the option of selecting a Preferred Provider or a Non-Preferred Provider. By choosing a Dental Network of America Dentist, Your out-of-pocket expenses are generally less than the amount owed if Non-Preferred Providers had been used.

When You receive care from a Preferred Provider:

1. confirm the Dentist's continued Dental Network of America PPO Network participation at each visit;
2. Your Dentist is responsible for submitting Your claim to FDL. You do not need to submit claims for Covered Dental Services; and
3. you are not responsible for charges that exceed the Allowable Amount.

You are responsible for:

1. any Deductibles;
2. any amounts in excess of maximums;
3. Coinsurance Amounts; and
4. services that are limited or not covered by the Plan.

If Your Dentist is not a Preferred Provider, You may be responsible for filing Your claim, as described in **CLAIMS FILING PROCEDURES, Who Files Claims** subsection, and for payment in full at the time services are rendered.

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

You must give written notice to FDL within 90 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if You show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

Claim Forms

When FDL receives notice of claim, it will furnish to You, or to the Policyholder for delivery to You, or the Dentist, the dental claim forms that are usually furnished by it for filing Proof of Loss. Claim forms may also be obtained by accessing the FDL website at www.FDL-life.com.

If the forms are not furnished within 15 days after receipt of notice by FDL, You have complied with the requirements of the Plan for Proof of Loss by submitting, within the time fixed under the Plan for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

FDL must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Provider -filed claims

Preferred Providers are responsible for submitting Your claims directly to FDL for services provided to You or any of Your covered Dependents. To assist Dentists in filing Your claims, You should carry Your Identification Card with You.

Participant-filed claims

If Your Dentist is not a Preferred Provider, You may need to submit Your claim to FDL using a form provided by FDL. The Policyholder should have a supply of dental claim forms. It is important to file each Participant's expenses separately because Deductibles, maximum benefits, and other provisions are applied for each Participant separately.

Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill FDL. Written agreements between Dental Network of America and some Dentists may require payment directly to them, even if You file the claim. Any benefits payable to You, if unpaid at Your death, will be paid to Your beneficiary or to Your estate if no beneficiary is named.

Except as provided in the section **ASSIGNMENT AND PAYMENT OF BENEFITS**, rights and benefits under this Plan shall not be assignable, either before or after services and supplies are provided.

Benefits for services provided to Your minor Dependent child may be paid to a third party if:

1. the third party is named in a court order as managing or possessory conservator of the child; and
2. FDL has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to FDL, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator or guardian of the estate of the child.

FDL may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to You or Your Dentist, or deduction by FDL from benefit payments of amounts owed to FDL will be considered in satisfaction of its obligations to You under this Plan.

An *Explanation of Benefits* summary is sent to You so You will know what has been paid.

When to Submit Claims

All claims for benefits under this Plan must be properly submitted within 90 days of the date You receive the services or supplies. Claims not submitted and received by FDL within 12 months after the date You receive the services or supplies will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by FDL

A claim will be considered received by FDL for processing upon actual delivery to the FDL Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied, or FDL may contact either You or the Dentist for the additional information.

Review of Claim Determinations

Claim Determinations

When FDL receives a properly submitted claim, FDL will make its benefit determinations in accordance with the Plan provisions. FDL will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If FDL requires further information in order to process the claim, we will request it within that 30 day period.

1. The provision entitled, ***Interpretation of the Policyholder's Plan Provisions***, is deleted in its entirety and replaced with the following:

Policyholder's Plan Provisions

FDL will make decisions concerning Plan provisions and eligibility and benefit determinations in accordance with the Plan provisions.

If a Claim Is Denied or Not Paid in Full

On occasion, FDL may deny all or part of Your claim. There are a number of reasons why this may happen. First, read the *Explanation of Benefits* summary prepared by FDL; then, review this Certificate to see whether You understand the reason for the determination. If You have additional information that You believe could change the decision, send it to FDL and request a review of the decision. Include Your full name, group and subscriber numbers with the request. If the claim is denied in whole or in part, You will receive a written notice, from FDL with the following information, if applicable:

1. the reasons for denial;
2. a reference to the dental care plan provision on which the denial is based;
3. a description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
4. an explanation of how You may have the claim reviewed by FDL if You do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review by FDL of any determination of a claim or any other determination made by FDL of Your benefits under this Plan.

If You believe FDL incorrectly denied all or part of Your benefits, You may have Your claim reviewed. FDL will review its decision in accordance with the following procedure:

1. within 180 days after You receive notice of a denial or partial denial, write to FDL's Administrative Office. FDL will need to know the reasons why You do not agree with the denial or partial denial.
2. You may also designate a representative to act for You in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative.
3. FDL will honor telephone requests for information; however, such inquiries will not constitute a request for review.
4. You and Your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical/dental information within 180 days after You receive notice of a denial or partial denial. FDL will give You a written decision within 60 days after it receives Your request for review.
5. if You have any questions about the claims procedures or the review procedure, write to FDL or call the number on Your Identification Card.
6. if You have a claim for benefits which is denied or ignored, in whole or in part, and Your Plan is governed by the Employee Retirement Income Security Act (ERISA), You may file suit under 502 (a) of ERISA.

Interpretation of the Policyholder's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. The Policyholder has given FDL full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits. Any decision by FDL which is not arbitrary or capricious shall be final and conclusive, subject to any applicable State and federal law.

Actions Against FDL

No lawsuit or action in law or equity may be brought by You or on Your behalf unless:

1. You first have fully complied with all of the provisions of the Plan, including all of the procedures and requirements of the **CLAIM FILING PROCEDURES** and **Review of Claim Determinations** subsection; and
2. FDL has either denied in writing Your request for review of the claim determination or has not provided a written response to Your request for review within 60 days after receiving the request; and
3. such lawsuit or action is brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished under the Plan.

DENTAL BENEFITS PROVIDED

Benefits are payable for Covered Dental Services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each benefit category is shown on the Schedule of Benefits.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

HOW BENEFITS ARE CALCULATED

Benefits are paid based on the Coinsurance Amount percentage shown on the Schedule of Benefits for each category as it is applied to the Allowable Amount. To determine benefits, the Deductible (if not previously satisfied) is subtracted from the Allowable Amount for a category. This amount is then multiplied by the Coinsurance Amount percentage for that category. The resulting total is the benefit payable by FDL.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, any Deductible and the Coinsurance Amount percentage will be Your responsibility to pay to Your Dentist.

DEDUCTIBLE

The Deductible shown on the Schedule of Benefits will be subtracted once during each Calendar Year from the total eligible Covered Dental Services incurred for that Calendar Year. It will apply to each benefit category, unless the Schedule of Benefits indicates it is waived for a particular benefit category. It will apply to each Participant. The following exceptions will apply:

1. if "Three-Month Deductible Carryover" is shown on the Schedule of Benefits, any Covered Dental Services incurred during the last three months of a Calendar Year and applied toward satisfaction of the Deductible for that Calendar Year, may be applied toward satisfaction of that Deductible for the following Calendar Year.
2. when any number of family Participants has satisfied the Family Deductible for a Calendar Year, any other Participants under Your coverage will not have to satisfy a Deductible for that Calendar Year.

ALLOWABLE AMOUNT DETERMINATION

In determining the Allowable Amount, FDL will consider such factors as Your Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances. The portion of the charges by Your Dentist that exceeds the Allowable Amount of FDL will be Your responsibility to pay to Your Dentist. In other words, a certain amount of the Dentist's charge may not be considered by FDL for benefits. Refer to the **DEFINITIONS** section for a detailed explanation of Allowable Amount.

CURRENT DENTAL TERMINOLOGY (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled Current Dental Terminology and Procedure Codes (CDT) is used when classifying dental services.

The Allowable Amount for a Covered Dental Service will be based on the most inclusive procedure codes.

COURSE OF TREATMENT

Your Dentist may decide on a planned series of dental procedures which a dental exam shows You need. In cases where there is more than one professionally acceptable Course of Treatment, benefits will be covered for the most economical procedures.

PREDETERMINATION OF BENEFITS

The Schedule of Benefits may indicate a "Predetermination Amount." If a Course of Treatment for non-emergency services can reasonably be expected to involve Covered Dental Services in excess of this predetermination amount, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by FDL prior to the commencement of treatment.

FDL may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. FDL will review the reports and materials, taking into consideration alternative Courses of Treatment. FDL will notify You and the Dentist of the benefits to be provided under the Plan. Predetermination gives You and Your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

MAXIMUM BENEFITS

Maximum Calendar Year Benefits

The maximum amount of benefits available for all combined Covered Dental Services for a Calendar Year for any one Participant is the amount shown on the Schedule of Benefits.

Depending on the terms of the Plan, it may also include any benefits provided under the Policyholder's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

Maximum Lifetime Benefits

The maximum lifetime benefits available for any one Participant for Orthodontic, Implant or Temporomandibular Joint (TMJ) Services is the amount shown on the Schedule of Benefits if applicable to Your coverage. Maximum lifetime benefit amounts do not apply to any other Covered Dental Services.

Depending on the terms of the Plan, it may also include any benefits provided under the Policyholder's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

CHANGES IN BENEFITS

Changes in benefits will apply to all services provided to each Participant under this Plan.

Benefits for Covered Dental Services incurred during a Course of Treatment which begins before the change will be the benefits in effect on the date the Course of Treatment was started.

COVERED DENTAL SERVICES

The Plan will provide benefits for the following Covered Dental Services, subject to the limitations and Exclusions described in this Certificate. **You are covered only for those benefit categories shown on the Schedule of Benefits**. The benefit percentage applicable to each benefit category is shown on the Schedule of Benefits.

The Listing of Covered Dental Services is a complete list of Covered Dental Services. We will not pay benefits for expenses incurred for any service not listed below, unless We agree to accept an unlisted service as a Covered Dental Service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. The choice of whether or not to accept an unlisted service is solely Ours. If We do accept an unlisted service as a Covered Dental Service, benefits will be payable on a basis consistent with benefits for similar Covered Dental Services which would provide the least costly adequate treatment of a Participant's dental condition according to broadly accepted standards of professional dental care as determined by Us.

Diagnostic and Preventive Care

Services that are used to prevent dental disease or to determine the nature or cause of a dental disease:

a. Routine oral evaluations (limited to two per Calendar Year).

b. X-rays (dental radiographs):

   i. full mouth or panorex x-ray limited to once every 36 months;

   ii. bitewing limited to 4 horizontal films or 8 vertical films twice per Calendar Year; and

   iii. other x-rays as necessary for diagnosis (except in connection with a program of orthodontics).

c. Professional cleaning, scaling and polishing teeth (prophylaxis) limited to two per Calendar Year.

d. Fluoride treatment (topical application), limited to two per Calendar Year for Participants up to age 19.

Miscellaneous Services

a. Sealants, limited to one per unrestored permanent molar for Participants up to age 16.

b. Space maintainers for Participants up to age 19.

c. Pulp vitality tests.

d. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment.

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration.

a. Amalgam restorations limited to once per surface per tooth in any Calendar Year.

b. Pin retention, per tooth, in conjunction with the restoration.

c. Composite restorations limited to once per surface per tooth per Calendar Year.

d. Simple tooth extraction.

General Services

a. Intravenous sedation.

b. General Anesthesia.

c. House call.

d. Injection of Antibiotic drugs.

e. Stainless steel crowns limited to one per tooth in a 60 month period and not to be used as a temporary crown.

Endodontic Services

Dental Services for prevention, diagnosis and treatment of diseases and injuries affecting the tooth and dental pulp.

a. Root canal therapy including treatment plan, clinical procedures, pre and post-operative radiographs and follow-up care.

b. Direct pulp cap.

c. Apicoectomy/periradicular services.

d. Apexification/recalcification.

e. Retrograde filling.

f. Root amputation/hemisection.

g. Therapeutic pulpotomy.

h. Gross pulpal debridement.

Periodontal Services

Dental Services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone) limited to two exams per Calendar Year. Periodontal maintenance includes the following:

a. Periodontal scaling and root planing limited to one time per quadrant per Calendar Year;

b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per Calendar Year;

c. Gingivectomy or gingivoplasty limited to one time per quadrant per Calendar Year;

d. Gingival flap procedure (includes root planing) limited to one time per quadrant per Calendar Year;

e. Osseous surgery, including flap entry with closure limited to one time per quadrant per Calendar Year;

f. Osseous grafts limited to one time per site per Calendar Year; and

g. Soft tissue grafts (includes donor site).

Oral Surgery Services

Dental Services for the treatment of certain dental conditions by operative or cutting procedures.

a. Surgical tooth extractions.

b. Alveoloplasty.

c. Vestibuloplasty.

d. Other Dentally Necessary surgical procedures.

Crowns, Inlays/Onlays Services

Dental services resulting from extensive disease or fracture limited to one per tooth in a 60 month period.

a. Prefabricated post and cores.

b. Cast post and cores.

c. Crown, inlays/onlays repairs

d. Recementation of inlays/onlays, crowns.

Benefits include the replacement of a lost or defective crown whether placement was under this Plan or under any prior dental coverage and even if the original crown was stainless steel.

Benefits will not be provided for replacement of dentures, crowns, inlays/onlays, removable or fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.

Prosthodontic Services

Dental services that restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitute. Covered Services include bridges, partial dentures and complete dentures.

a. Initial installation of bridgework (including inlays and crowns as abutments) limited to once per tooth in any 60 month period, whether placement was under this Plan or under any prior dental coverage.

   i. Bridge repair.

   ii. Recementing a bridge.

   iii. Post and core buildup.

b. Initial installation of removable complete, immediate or partial dentures (including any adjustments, relines or rebases during the 6 month period following installation) limited to once in any 60 month period, whether placement was under this Plan or under any prior dental coverage.

   Benefits are available for the replacement of complete or partial dentures, but only if the appliance is 60 months old or older and cannot be made serviceable.

c. Adjustments limited to 3 times per appliance in any Calendar Year.

d. Repairs.

e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) limited to a lifetime maximum of once per tooth.

f. Denture rebase and reline procedures limited to one in any 36 month period.

EXCLUSIONS

In addition to those benefit maximums and limitations described in DENTAL **BENEFITS PROVIDED**, *the benefits of the Plan are not available for any Covered Dental Services incurred:*

1. In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
2. For which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
3. As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
4. Primarily for cosmetic purposes, including but not limited to bleaching teeth, grafts to improve esthetics, except for:
   a. Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
   b. Covered orthodontic diagnostic procedures and treatment; or
   c. Services provided to a newborn child which are necessary for treatment or correction of congenital defects.
5. For services or supplies which do not meet accepted standards of dental practices.
6. For services provided or received for:
   a. behavior management; or
   b. consultation purposes.
7. For Benefits for an alternate Course of Treatment which exceeds the most economical procedures.
8. For personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes; for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the America Dental Association; and for services or supplies not Dentally Necessary.
9. For treatment provided before the effective date of a Participant's coverage or after termination of coverage under this Plan.
10. For appliances, materials, restorations, or special equipment used to increase vertical dimension, correct or restore the occlusion except as may be provided on the Schedule of Benefits.
11. To correct temporomandibular joint (TMJ) dysfunction or pain syndromes except as may be provided on the Schedule of Benefits.
12. For which benefits are otherwise provided under inpatient hospital expense or medical-surgical expense coverage under the medical benefits of the health benefit plan.
13. For treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.
14. For replacement or repair of an orthodontic appliance.

15. For services or supplies when:
    a. no charge is made;
    b. the Participant is not legally obligated to pay;
    c. no charge would be made in the absence of this or similar dental coverage;
    d. “discounts” or waiver of a Deductible or Coinsurance Amounts are offered;
    e. treatment is received by a Dentist who is related to the Participant by blood or marriage; or
    f. treatment is provided through a medical department, clinic, or similar facility furnished or maintained by the Policyholder.
16. For a duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
17. For:
    a. dietary and oral hygiene instruction, a plaque control program and tobacco use counseling; and
    b. For prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
18. For any charge:
    a. Resulting from the failure of a Participant to keep a scheduled visit with a Dentist; or
    b. For completion of any insurance forms; or
    c. For telephone consultations; or
    d. For records or x-rays necessary for FDL to make a benefit determination.
19. For splinting, grafting and preparation associated with Implants, if “Implants” is not indicated on Your Schedule of Benefits.
20. For splinting of teeth, including double abutments for prosthetic abutments.
21. For Accidental Injuries including tooth transplantation.
22. For pin retention **not** performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
23. For administration of any local anesthesia, and necessary infection control as required by OSHA, state and federal mandates billed separately.
24. For palliative (emergency) treatment performed in conjunction with definitive dental treatment.
25. For indirect pulp capping.
26. For athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/ malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
27. For bacteriological studies for determination of pathologic agents and soft tissue allograft.
28. For biologic materials, cytology sample collection and histopathological examinations.
29. For canal preparation and fitting of prefabricated dowel and post if billed separately.
30. For caries susceptibility tests.
31. For chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
32. For crowns to restore occlusion or incisal edges due to bruxism or harmful habits.
33. For desensitizing medicaments and/or their application.

DEFINITIONS

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

Actively at Work means that You are:

1. performing the normal duties of Your occupation; and
2. working the number of hours set forth in the Application.

Allowable Amount means the maximum amount determined by FDL to be payable for a particular service, supply, or procedure. To calculate the Allowable Amount, FDL uses the most appropriate method in consideration of the Dentist and/or type of service as follows:

1. For Preferred Providers, the Allowable Amount is the lesser of:
   a. the Maximum Allowance for the service or supply; and
   b. the amount charged by the Preferred Provider for the service or supply.
2. For non-Preferred Providers, the Allowable Amount is the lesser of:
   a. the Reasonable and Customary Charge for the service or supply; and
   b. the amount charged by the provider for the service or supply

Unless otherwise stipulated by a contract between the Dentist and carrier:

1. an Allowable Amount will be established by identifying Dentists with similar experience or skill in order to establish the applicable amount for the procedure, services, or supplies.
2. for multiple surgical procedures performed in the same operative area, the Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
3. when a less expensive professionally acceptable service, supply, or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Covered Dental Services also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

Annual Enrollment means the 31-day period preceding the next Policy Anniversary during which Employees and Dependents may enroll for coverage.

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. The Application is attached to and forms a part of this Policy, and shall include any subsequent amendments to the Application.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Coinsurance Amount means the dollar amount of Covered Dental services eligible for benefits that are incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Covered Dental Services means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant acquires an obligation for payment.

Deductible means the dollar amount of Covered Dental Services that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or **Dental Necessity** means those services, supplies, or appliances covered under the Plan which are:

1. essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. not primarily for the convenience of the Participant or his Dentist; and
4. the most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

FDL shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Eligibility Date means the date the Participant satisfies the definition of either Employee or Dependent or Retiree and is in a class eligible for coverage under the Plan as described in **WHO GETS BENEFITS**.

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

Employer means, in addition to the person, firm, or institution named on the cover of this Certificate, one or more subsidiaries or affiliates, if any, listed on the Policy face page.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

1. have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. are appropriate for the hospital or facility in which they were performed; and
3. the Dentist has had the appropriate training and experience to provide the treatment or procedure.

FDL shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational within this definition.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, FDL still may determine such services or supplies to be Experimental/ Investigational within this definition. Treatment provided as a part of a clinical trial or a research study is Experimental/ Investigational.

Maximum Allowance means the amount determined by FDL which Preferred Providers have agreed to accept as payment in full for a particular Covered Dental Service. These amounts may be amended from time to time by FDL.

Participant means an Employee, Dependent, or a retired Employee whose coverage has become effective under this Plan.

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

Policy Anniversary means the month, day, and year specified on the Application and the corresponding date in each year thereafter for as long as the Policy is in force.

Policy Effective Date means the date on which coverage under the Policy with FDL commences.

Policy Month means each succeeding monthly period, beginning on the Policy Date.

Policy Year means the first Policy Year beginning on the Policy Effective Date of coverage and ending 12 months later. Subsequent Policy Years begin on the Policy Anniversary dates and end 12 months later.

Policyholder means the person, firm, or institution named in the Policy, including any covered subsidiaries or affiliates named in the Policy.

Preferred Provider means a dentist, dental hygienist, dental office or medical center or any dental care provider who is a participant in FDL's Preferred Provider plan.

Proof of Loss means written evidence of a claim including:

1. the form on which the claim is made;
2. bills and statements reflecting dental services, supplies, and appliances furnished to a Participant and amounts charged for those services, supplies, and appliances that are covered by the claim; and
3. correct diagnosis and procedure code(s) for the services and items.

Reasonable and Customary means charges made for services or supplies essential to the care of the individual. Charges will be considered reasonable and customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonably and customary, FDL considers the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience.

You or Your means the Employee or Retiree to whom this Certificate has been delivered.

We, Our, Us means Fort Dearborn Life Insurance Company.

GENERAL INFORMATION

PARTICIPANT/DENTIST RELATIONSHIP

The choice of a Dentist is made solely by a Participant. FDL does not furnish services but only makes payment for Covered Dental Services incurred by Participants. FDL is not liable for any act or omission by any Dentist and FDL does not have any responsibility for a Dentist's failure or refusal to provide services to a Participant.

ASSIGNMENT AND PAYMENT OF BENEFITS

If a written assignment of benefits is made by a Participant to a Preferred Provider and the written assignment is delivered to FDL with the claim for benefits, FDL will make any payment directly to the Preferred Provider. Payment to the Preferred Provider discharges FDL's responsibility to the Participant for any benefits available under the Plan.

SUBROGATION

If FDL pays or provides benefits for You or Your Dependents under this Plan, FDL is subrogated to all rights of recovery which You or Your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits FDL has paid or provided. That means FDL may use Your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

For the purposes of this provision, *subrogation* means the substitution of one person or entity (FDL) in the place of another (You or Your Dependent) with reference to a lawful claim, demand, or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, FDL will have a right of reimbursement.

If You or Your Dependent recover money from any person, organization, or insurer for an injury or condition for which FDL paid benefits under this Plan, You or Your Dependent agree to reimburse FDL from the recovered money for the amount of benefits paid or provided by FDL.

That means You or Your Dependent will pay to FDL the amount of money recovered by You through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization, or insurer, up to the amount of benefits paid or provided by FDL.

Right to Recovery by Subrogation or Reimbursement

You or Your Dependent agree to promptly furnish to FDL all information which You have concerning Your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with FDL in protecting and obtaining its reimbursement and subrogation rights. You, Your Dependent, or Your attorney will notify FDL before settling any claim or suit so as to enable Us to enforce our rights by participating in the settlement of the claim or suit. You or Your Dependent further agree not to allow the reimbursement and subrogation rights of FDL to be limited or harmed by any acts or failure to act on Your part.

REFUND OF BENEFIT PAYMENTS

If FDL pays benefits for Covered Dental Services incurred by You or Your covered Dependents and it is found that the payment was more than it should have been, or was made in error, FDL has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, FDL may deduct any refund due it from any future benefit payment.

COORDINATION OF BENEFITS

The availability of benefits specified in this Policy is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has dental coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:

   a. group or blanket insurance;

   b. franchise insurance that terminates upon cessation of employment;

   c. group dental service plans and other group prepayment coverage;

   d. any coverage under labor-management trusteed arrangements, union welfare arrangements, or employer organization arrangements;

   e. governmental plans, or coverage required or provided by law.

   Plan does *not* include:

   a. any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;

   b. a policy of dental insurance that is individually underwritten and individually issued;

   c. school accident type coverage; or

   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

   Each Policy or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Policy that provides benefits for dental expenses.

3. **Primary Plan/Secondary Plan**

   The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

   When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for dental care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means Fort Dearborn Life Insurance Company (FDL).

Order of Benefit Determination Rules

1. ***General Information***

   When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless

   a. the other Plan has rules coordinating its benefits with those of This Plan, and

   b. both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

2. ***Rules***

This Plan determines its order of benefits using the first of the following rules which applies:

a. ***Non-Dependent/Dependent*** – The benefits of the Plan which covers the Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

i. secondary to the Plan covering the Participant as a Dependent; and

ii. primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

b. ***Dependent Child/Parents Not Separated or Divorced*** – Except as stated in paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

i. The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

ii. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced*** – If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

i. First, the Plan of the parent with custody of the child;

ii. Then, the Plan of the spouse of the parent with custody, if applicable;

iii. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph c does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody –*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.

e. ***Active/Inactive Employee*** – The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph e does not apply.

f. ***Continuation Coverage*** – If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

i. First, the benefits of a Plan covering the Participant as an Employee, member, or subscriber (or as that Participant's Dependent);

ii. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage*** – If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of this Plan

1. ***When This Section Applies***

   This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. ***Reduction in this Plan's Benefits***

   a. The benefits of This Plan will be reduced when the sum of:

      i. the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

      ii. the benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

   b. If This Plan is a Secondary Plan, the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are the lessor of:

      i. the benefits that would be payable under This Plan without applying the Coordination of Benefits Provision; and

      ii. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions.

   In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information We need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give Us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons we have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Dentists; or
4. any other person or organization.

INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If the Plan is part of an "employee welfare benefit plan" and "welfare plan" as those terms are defined in ERISA, the responsibilities of the Policyholder, You, and FDL include the following:

1. the Policyholder will furnish summary plan descriptions, annual reports, and summary annual reports to You and other plan participants and to the government as required by ERISA and its regulations.
2. FDL will furnish the Policyholder with this Certificate as a description of benefits available under the Plan. Upon written request by the Policyholder, FDL will send any information which FDL has that will aid the Policyholder in making its annual reports.
3. claims for benefits must be made in writing on a timely basis in accordance with the provisions of the Plan. Claim filing and claim review procedures are found in the **DENTAL BENEFITS PROVIDED** section of this Certificate.
4. FDL is not the ERISA "plan administrator" for benefits or activities pertaining to the Plan.
5. this Certificate is a Certificate of Coverage and not a Summary Plan Description.
6. the Policyholder has given FDL the authority and discretion to interpret the Plan provisions and to make eligibility and benefit determinations.

AMENDMENTS

The Plan may be amended or changed from time to time by the Policyholder and/or FDL. No notice to or consent by any Participant is necessary to amend or change the Plan.

AGENT

The Policyholder is not the agent of FDL.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer's group health **plan** (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to You and Your family, and
- What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the Certificate or Certificate of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage ***may*** last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.

FORT DEARBORN LIFE INSURANCE COMPANY

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

Chicago, Illinois

AMENDATORY RIDER

(Illinois State Laws)

This Rider is a part of the Policy and/or Certificate to which it is attached. It is subject to all the terms of the Policy which are not in conflict with the terms of this Amendatory Rider.

TIME OF PAYMENT OF CLAIMS

The Time of Payment of Claims provision is amended by adding the following:

Failure to pay benefits within such period shall entitle You to interest at the rate of 9% per annum from the day after receipt of such due proof of loss to the date of late payment.

CONTINUATION OF COVERAGE AFTER TERMINATION

The purpose of this provision of the Amendatory Rider is to explain the options available for continuing coverage after termination, as it relates to Illinois state legislation. The provisions which apply will depend upon Your or Your Dependent's status at the time of termination.

The provisions described in ARTICLE I will apply to Your insured spouse upon dissolution of marriage, Your death, or Your retirement (if Your spouse is at least 55 years of age).

The provisions described in ARTICLE II will apply to Your insured Dependent child, if You have died, or if Your insured Dependent child has reached the limiting age under the Certificate and is not eligible to continue coverage as provided under Article I.

Your Dependent's continued coverage under the Certificate will be provided only as specified below. Therefore, after it is determined which Article applies, please read the provisions very carefully.

ARTICLE I - CONTINUATION OF COVERAGE FOR AN INSURED EMPLOYEE'S FORMER SPOUSE OR AN INSURED EMPLOYEE'S SPOUSE UPON THE EMPLOYEE'S DEATH OR RETIREMENT

If the coverage of Your Dependent spouse should terminate because of Your dissolution of marriage, Your death, or Your retirement, the former Dependent spouse or Dependent spouse (a retired Employee's spouse if at least 55 years of age) will be entitled to continue the coverage provided under this Certificate for himself and his eligible dependents (if Dependent Coverage is in effect at the time of termination). However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to Your former spouse or Your spouse, only if he provides Your employer with written notice of the dissolution of Your marriage, Your death or Your retirement within 30 days of such event.
2. Within 15 days of receipt of such notice, Your Employer will give written notice to FDL of the dissolution of Your marriage, Your death, or Your retirement as well as notice of Your former spouse or spouse's address. Such notice will include the Group number and the insured Employee's identification number under this Certificate. Within 30 days of receipt of notice from Your Employer, FDL will advise Your former spouse or spouse at their residence, by certified mail, return receipt requested, that Your former spouse or spouse's coverage and Your covered Dependent children under this Certificate may be continued. FDL's notice to Your former spouse or spouse will include the following:
    a. a form for election to continue coverage under this Certificate.
    b. notice of the amount of monthly premium charges to be paid by Your former spouse or spouse for such continuation of coverage and the method and place of payment.

c. instructions for returning the election form within 30 days after the date it is received from FDL.

3. In the event Your former spouse or spouse fail to provide written notice to FDL within the 30 days specified above, benefits will terminate for Your former spouse or spouse on the date coverage would normally terminate for a former spouse or spouse of a retired insured Employee under this Certificate as a result of the dissolution of marriage, the death or the retirement of the insured Employee. Your former spouse or spouse's right to continuation of coverage will then be forfeited.

4. If FDL fails to notify Your former spouse or spouse as specified above, all premium charges shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of FDL's notice was to be sent are terminated as to all insured Employees under Your Employer's coverage under the Policy.

5. If Your former spouse has not reached age 55 at the time his continued coverage begins, the monthly premium will be computed as follows:

   a. an amount, if any, that would be charged Your former spouse if he were an insured Employee, with Employee or Family coverage, as the case may be, plus,

   b. an amount, if any, that the Employer would contribute toward the premium if Your former spouse were the insured Employee under this Certificate.

Failure to pay the initial monthly premium charge within 30 days after receipt of notice from FDL as required in this Article will terminate Your former spouse's continuation benefits and the right to continuation of coverage.

6. If Your former spouse or Your spouse has reached age 55 at the time his continued coverage begins, the monthly premium will be computed for the first 2 years as described above. Beginning with the third year of continued coverage, an additional charge, not to exceed 20% of the total amounts specified in (5) above will be charged for the costs of administration.

7. Termination of Continuation of Coverage:

If Your former spouse has not reached age 55 at the time his continued coverage begins, his continuation of coverage shall end on the first to occur of the following:

   a. if Your former spouse fails to make any payment of premium when due (including any grace period specified in the Policy).

   b. on the date coverage would otherwise terminate under this Certificate if Your former spouse and You were still married; however, his coverage shall not be modified or terminated during the first 120 consecutive days following Your death or entry of judgment dissolving the marriage existing between Your former spouse and You, except in the event Your Employer's coverage under the Policy is modified or terminated.

   c. the date on which Your former spouse remarries.

   d. the date on which Your former spouse becomes an insured employee under any other group health plan.

   e. the expiration of 2 years from the date Your former spouse's continued coverage under this Certificate began.

8. If Your former spouse or spouse has reached age 55 at the time his continued coverage begins, Your former spouse or spouse's continuation of coverage shall end on the first to occur of the following:

   a. if Your former spouse or spouse fail to make any payment of premium when due (including any grace period specified in the Policy).

   b. on the date coverage would otherwise terminate, except due to Your retirement, under this Certificate if Your former spouse and You were still married; however, his coverage shall not be modified or terminated during the first 120 consecutive days following Your death, retirement or entry of judgment dissolving the marriage existing between Your former spouse and You, except in the event Your Employer's coverage under the Policy modified or terminated.

   c. the date on which Your former spouse remarries.

d. the date on which Your former spouse or spouse becomes an insured employee under any other group health plan.

e. the date upon which Your former spouse or spouse reach the qualifying age or otherwise establish eligibility under Medicare.

9. If Your former spouse or spouse exercise the right to continuation of coverage under this Certificate he shall not be required to pay premium charges greater than those applicable to any other insured Employee covered under Your Employer's coverage under the Policy, except as specifically stated in these provisions.

10. Upon termination of Your former spouse's continuation of coverage, he shall be entitled to convert the coverage to an individual policy.

11. If Your Employer's coverage under the Policy cancelled and another insurance company contracts to provide group health insurance at the time Your former spouse's or spouse's continuation of coverage is in effect, the new insurer must offer continuation of coverage to Your former spouse or spouse under the same terms and conditions described in this Certificate.

ARTICLE II - CONTINUATION OF COVERAGE FOR AN INSURED EMPLOYEE'S DEPENDENT CHILD

If the coverage of Your Dependent child should terminate because of Your death and Your Dependent child is not eligible to continue coverage under ARTICLE I or Your Dependent child has reached the limiting age under this Certificate, Your Dependent child will be entitled to continue the coverage provided under this Certificate for himself. However, this continuation of coverage option is subject to the following conditions:

1. Continuation will be available to Your Dependent child, only if he or a responsible adult acting on his behalf, provide Your Employer with written notice of Your death within 30 days of the date the coverage terminates.

2. If continuation of coverage is desired because Your Dependent child has reached the limiting age under this Certificate, he must provide Your Employer with written notice of the attainment of the limiting age within 30 days of the date the coverage terminates.

3. Within 15 days of receipt of such notice, Your Employer will give written notice to FDL of Your death or of Your Dependent child reaching the limiting age, as well as notice of Your Dependent child's address. Such notice will include the Group number and Your identification number under this Certificate. Within 30 days of receipt of notice from Your Employer, FDL will advise Your Dependent child at his residence, by certified mail, return receipt requested, that his coverage under this Certificate may be continued. FDL's notice will include the following:

   a. a form for election to continue coverage under this Certificate.

   b. notice of the amount of monthly premium to be paid by Your Dependent child or a responsible adult on his behalf, for such continuation of coverage and the method and place of payment.

   c. instructions for returning the election form within 30 days after the date it is received from FDL.

4. In the event Your Dependent child, or the responsible adult acting on his behalf, fail to return the election form to FDL within the 30 days specified above, benefits will terminate for Your Dependent child on the date coverage would normally terminate for Your Dependent child under this Certificate as a result of Your death or Your Dependent child attaining the limiting age. Your Dependent child's right to continuation of coverage will then be forfeited.

5. If FDL fails to notify Your Dependent child as specified above, all premium shall be waived from the date such notice was required until the date such notice is sent and benefits shall continue under the terms of this Certificate from the date such notice is sent, except where the benefits in existence at the time of FDL's notice was to be sent are terminated as to all insured Employees under Your Employer's coverage under the Policy.

6. The monthly premium charge will be computed as follows:

   a. an amount, if any, that would be charged to Your Dependent child if he were an insured Employee, plus,

   b. an amount, if any, that the Employer would contribute toward the premium if Your Dependent child were the insured Employee under this Certificate.

Failure to pay the initial monthly premium charge within 30 days after receipt of notice from FDL as required in this Article will terminate Your Dependent child's continuation benefits and the right to continuation of coverage.

7. Continuation of Coverage shall end on the first to occur of the following:
    a. if Your Dependent child or a responsible adult acting on his behalf, fails to make any payment of premium charges when due (including any grace period specified in the Policy).
    b. on the date coverage would otherwise terminate under this Certificate if Your Dependent child were still an eligible Dependent child of the insured Employee.
    c. the date on which Your Dependent child becomes an insured employee, after the date of election, under any other group health plan.
    d. the expiration of 2 years from the date Your Dependent child continued coverage under this Certificate began.
8. If Your Dependent child exercises the right to continuation of coverage under this Certificate, he shall not be required to pay premium charges greater than those applicable to any other insured Employee covered under Your Employer's coverage under the Policy, except as specifically stated in these provisions.
9. Upon termination of Your Dependent child's continuation of coverage, he shall be entitled to convert coverage to an individual policy.
10. If Your Employer's coverage under the Policy cancelled and another insurance company contracts to provide group health insurance at the time Your Dependent child's continuation of coverage is in effect, the new insurer must offer continuation of coverage to Your Dependent child under the same terms and conditions described in this Certificate.

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

President

NOTICE OF

PROTECTION PROVIDED BY

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amount of coverage.

The Association was established to provide protection in the unlikely event that your member 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 Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*****
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*****The maximum amount of protection for each individual, regardless of the number of policies or contracts, in $300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

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 residency requirements and other limitations under Illinois law.

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

Illinois Life and Health	*Illinois Department of Insurance*

Insurance Guaranty Association	*4th Floor*
8420 West Bryn Mawr Avenue, Suite 550	*320 West Washington Street*
Chicago, Illinois 60631-3404	*Springfield, Illinois 62767*
(773) 714-8050	*(217) 782-4515*

Insurance companies and agents are not allowed by Illinois 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 an inconsistency between this notice and Illinois law, then Illinois law will control.

NOTICE (IL)

DISCLOSURE OF LIMITED BENEFIT

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of you benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION**. Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

FORT DEARBORN LIFE INSURANCE COMPANY

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

Chicago, Illinois

AMENDATORY RIDER

(Illinois State Laws)

This rider is a part of the Policy and/or Certificate to which it is attached. It is subject to all the terms of the Policy which are not in conflict with the terms of this Amendatory Rider.

A. The "Dependent child age limit" specified in the **SCHEDULE OF BENEFITS** is deleted in its entirety and is replaced with the following:

Dependent child age limit: to age 26; or, up to age 30 if an Illinois resident and a released or honorably discharged member of the United States Armed Forces.

B. The ***Dependent Eligibility*** provision is deleted entirely and replaced with the following:

Dependent Eligibility

For the purposes of this provision, an eligible Dependent includes:

1. an eligible Employee's lawful spouse, including a spouse or former spouse for whom the Employee has received a court order to maintain financial responsibility for providing health insurance; or

2. any unmarried child of an eligible Employee, to age 26, who is not in active military service, including:
   a. the Employee's natural child; or
   b. the Employee's legally adopted child;
   c. the Employee's stepchild; or
   d. a child for whom the Employee has received a court order to maintain financial responsibility for providing health insurance.

3. any unmarried children of an eligible Employee, at least 26 years of age:
   a. who are primarily dependent upon the Employee for support and maintenance and who cannot work to support themselves due to a physical or mental incapacity;
   b. who was incapacitated and insured under the Policy on his 26th birthday; and
   c. who continues to be incapacitated beyond his 26th birthday;

4. any unmarried child of an eligible Employee, to age 30 if the Dependent:

   a. is an Illinois resident;

   b. served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and

   c. has received a release or discharge other than a dishonorable discharge.

   To be eligible for coverage under subsection 4. the eligible Dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the Dependent was released from service.

A person cannot be insured as an Employee and also as a Dependent under the Plan. If both the husband and the wife are covered as Employees under the Plan, only one may enroll for dental coverage on Dependent child(ren)

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

President

Administrative Office: 1020 31st Street

Downers Grove, Illinois 60515

FORT DEARBORN LIFE INSURANCE COMPANY

Chicago, Illinois

AMENDATORY ENDORSEMENT

This Amendatory Endorsement amends the Policy or Certificate to which it is attached. It takes effect and ends at the same time as the Policy or Certificate to which it is attached. All provisions of the Policy or Certificate will apply to this Amendatory Endorsement, except that in the event of a conflict, the specific provisions of this Amendatory Endorsement will govern.

I.

Except as provided in "II." below, the term **Spouse**, wherever it appears in the Policy or Certificate, is amended as follows:

Spouse includes a **Party to a Civil Union**.

In addition to civil unions entered into under Illinois law, the term **Civil Union** includes a marriage between persons of the same sex, a civil union, a domestic partnership, or a substantially similar legal relationship, other than common law marriage, legally entered into in another jurisdiction.

II.

For purposes of the Continuation of Coverage Rights Notice ("COBRA"), Spouse does not include a same-sex Domestic Partner or Party to a Civil Union while prohibited by federal law. Similar benefits may be available under state law or by the policyholder. Refer to the Notice or Contact Your Plan Administrator if you have questions.

President

Nothing contained in this Amendatory Endorsement shall be held to alter or affect any provision or condition of the Policy or Certificate, other than as stated above.

Administrative Office:

1020 31st Street

Downers Grove Illinois 60515

Principal Office:

300 E. Randolph Street

Chicago Illinois 60601

Term Life and AD&D Insurance

Employee Benefit Booklet

VIVA USA, INC.

F1D1358-0001

Class 1-01

04/26/2012

FORT DEARBORN LIFE
Insurance Company®

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

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

Principal Office:
300 E. Randolph Street
Chicago IL 60601

Having issued Group Policy No. F1D1358-0001

(herein called the Policy)

to

VIVA USA, INC.
(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, and it takes effect as 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 Group Insurance Certificate (issued to *You*) are different from the policy (issued to the *Policyholder*), the Policy will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy.

READ YOUR CERTIFICATE CAREFULLY

Signed for Fort Dearborn Life Insurance Company

William R Barnes
Secretary

Craig K. Hordyk
President

Basic Group Term Life Insurance Certificate
with
Accidental Death & Dismemberment Benefits
Non-Participating

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SCHEDULE OF BENEFITS

***POLICYHOLDER*:**	VIVA USA, INC.
POLICY NUMBER:	F1D1358-0001
EFFECTIVE DATE:	May 1, 2012

ELIGIBILITY: **Class 01**	ALL ACTIVE FULL TIME EMPLOYEES 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:*	30 Days of continuous, full-time active work
	New *Employees:*	30 Days of continuous, full-time active work
Policyholder Contribution:	Basic Life & AD&D	75% of premium

GROUP TERM LIFE INSURANCE

***Employee* Basic Life Benefit Amount**	$15,000
Reduction of Benefits	Basic Group Term Life benefits reduce by 35% of the original amount at age 65 and further reduce to 40% of the original amount at age 70, 25% of the original amount at age 75, and 15% of the original amount at age 80. Benefits terminate at retirement.
Waiver of Premium	
Waiver Eligibility	Totally Disabled prior to age 60 without interruption from the last date worked for at least 9 months
Insured Eligibility	*Employee*
Maximum Waiver of Premium Duration	age 65
Accelerated Death Benefit (ADB)	
Benefit Amount	50% (75% is maximum in Illinois) Basic Term Life Insurance In force
Insured Eligibility	*Employee*
Minimum Covered Life Insurance Amount	$15,000
Maximum ADB Payment	$150,000
Minimum ADB Payment	$7,500

GROUP ACCIDENTAL DEATH & DISMEMBERMENT

***Employee* Basic AD&D Coverage Amount**	$15,000
Reduction of Benefits	Basic Accidental Death and Dismemberment benefits reduce by 35% of the original amount at age 65 and further reduce to 40% of the original amount at age 70, 25% of the original amount at age 75, and 15% of the original amount at age 80. Benefits terminate at retirement.
Seat Belt Benefit	10% of *Employee* Coverage Amount, to a maximum of $25,000
Air Bag Benefit	5% of *Employee* Coverage Amount to a maximum of $5,000
Repatriation Benefit	Actual costs to a maximum of $5,000
Education Benefit	
Benefit Amount	3% of *Employee* Coverage Amount, to a maximum of $3,000 per year
Maximum Benefit Duration	Benefit payable for a maximum of four (4)years
Eligible Dependents	Age live birth to age 19 years (23 if a full-time student)

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

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

The *Eligibility Waiting Period* is set forth in the Schedule of Benefits.

00001

When does Your Contributory insurance become effective?

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

You may apply for insurance coverage at any time. *Your* coverage will become effective as follows, provided You are Actively at Work on that date:

Your Contributory coverage for amounts up to the Guarantee Issue Benefit Limit will become effective on the latest of the following dates provided You are Actively at Work on that date:

1. If *You* enroll for coverage prior to the Policy effective date, the Policy effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for coverage within 31 days after *Your* eligibility date, You are considered a late applicant and must furnish Evidence of Insurability satisfactory to Us before coverage can become effective, unless *You* qualify because of a *Change in Family Status.*
    a. Coverage for a late applicant will become effective on the date *We* determine that the *Evidence of Insurability* is satisfactory and *We* provide written notice of approval.
    b. Coverage requested 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.

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

00004

Change in Family Status

If *You* experience a *Change in Family Status*, *You* may enroll for coverage, apply for additional coverage, or request changes to *Your* current 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.

00005-A

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 *Your* eligibility date; or
2. *You* voluntarily canceled *Your* insurance and choose to reapply; or
3. *Your* coverage amount exceeds the Guarantee Issue Benefit Limit as set forth in the Schedule of Benefits; or
4. *You apply to increase Your coverage amount during the Policy year.*

Receipt of premium before *We* have approved *Evidence of Insurability* will not constitute acceptance and does not guarantee issuance of any benefit amount prior to *Our* approval.

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 *Your* 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*.
00006

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

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

Your effective date for any initial coverage or increased coverage will be deferred until the first day *You* return to *Active Work.*

However, *You* will be considered *Actively at Work* on any day that is not *Your* regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if *You* were *Actively at Work* on the immediately preceding scheduled work day and *You* were:

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

00008

Changes to Your coverage

A change in *Your* coverage may occur if:

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

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

Additional coverage for reasons other than a Policy change will be effective as indicated in the ***"When Does Your Contributory insurance become effective?"*** section, or the later of:

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

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

00010

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.

If *You* converted all or part of *Your* group life insurance when employment terminated, the individual policy must be surrendered upon return to *Active Work*.

00011

TERM LIFE INSURANCE BENEFIT

THIS BENEFIT ONLY APPLIES TO YOU IF YOU HAVE ELECTED TERM LIFE INSURANCE AND YOU HAVE PAID OR AGREED TO PAY THE APPLICABLE PREMIUM.

When is a Life Insurance Benefit payable?

We will pay *Your* beneficiary the amount of life insurance in force as of the date of *Your* death provided:

1. *You* are insured under the Policy on the date of death, and
2. *We* receive proof of death within two (2) years after the date of death.

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

00012

Who will receive Your Life Insurance Benefits?

Your beneficiary designation must be made on a form which *We* provide or on a form accepted by *Us.* If two or more beneficiaries are named, payment of proceeds will be apportioned equally unless *You* had specified otherwise. The *Policyholder* may not be named as beneficiary. Unless *You* provide otherwise, if a beneficiary dies before *You*, *We* will divide that beneficiary's share equally between any remaining named beneficiaries.

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

Facility of Payment

If no named beneficiary survives *You* or if *You* do not name a beneficiary, We will pay the amount of insurance:

1. to *Your* spouse, if living; if not,
2. in equal shares to *Your* then living natural or legally adopted children, if any; if none,
3. in equal shares to *Your* father and mother, if living; if not,
4. in equal shares to *Your* brothers and/or sisters, if living; if not,
5. to *Your* estate.

If any benefits under this provision are to be paid to *Your* estate, *We* may pay an amount not greater than $1,000 to any person *We* consider equitably entitled by reason of having incurred funeral or other expenses incident to *Your* death. Any and all payments made by *Us* shall fully discharge *Us* in the amount of such payment.

00014

May You change Your beneficiary?

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

If *You* are approved for continued life coverage under the Waiver of Premium, *You* may be asked to name a beneficiary. A beneficiary designation made in connection with Waiver of Premium, if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the Policy. Such change of beneficiary only applies while *You* qualify for continued coverage under the Waiver of Premium provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are employed by the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.

00015

CONVERSION OF LIFE INSURANCE

How much Life Insurance may You convert if eligibility terminates?

You may convert to an individual policy of life insurance if *Your* life insurance, or a portion of it, ceases because:

1. *You* are no longer employed by the *Policyholder*; or
2. *You* are no longer in a class which is eligible for life insurance.

In either of these situations, *You* may convert all or any portion of *Your* life insurance which was in force on the date *Your* life insurance ceased.

How much Life Insurance may You convert if the policy terminates or is amended?

You may also convert to an individual policy of life insurance if *Your* life insurance ceases because:

1. life insurance benefits under the Policy cease; or
2. the Policy is amended making *You* ineligible for life insurance; however, in either of these situations,

You must have been insured under the Policy, or the Policy it replaced, for at least five (5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. the amount of life insurance in force, less any amount for which *You* become eligible under this or any other group policy within 31 days after the date *Your* life insurance ceased; or
2. $10,000.

How to apply for conversion

We must receive written application and the first premium for the individual life insurance policy within 31 days after life insurance under the Policy ceased. No *Evidence of Insurability* will be required.

The individual policy will be a policy of whole life insurance. It will not contain waiver of premium, accelerated death benefit, disability benefits, accidental death and dismemberment benefits or any other ancillary benefits.

The minimum issue amount of an individual conversion policy is $2,000. The premium for the individual policy will be based on:

1. *Our* current rates based upon *Your* attained age; and
2. the amount of the individual policy.

If application is made for an individual policy, the coverage under the individual policy will be effective on the day following the 31-day period during which *You* could apply for conversion.

If *You* die during a period when *You* would have been entitled to have an individual policy issued to *You* and if *You* die before such an individual policy became effective, *We* will pay *Your* beneficiary the greatest amount of group term life insurance for which an individual policy could have been issued, provided:

1. *Your* death occurred during the 31-day period within which *You* could have made application; and
2. *We* receive proof of death within two (2) years of the date of death.

If life insurance benefits are paid under the Policy, payment will not be made under the converted policy, and premiums paid for the converted policy will be refunded.

Notice. If the *Policyholder* fails to notify *You* at least 15 days prior to the date insurance under the Policy would cease, *You* shall have an additional period within which to elect conversion coverage; but nothing herein shall be construed to continue any insurance beyond the period provided for in the Policy. The additional election period shall expire 15 days immediately after the *Policyholder* gives *You* notice, but in no event shall it extend beyond 60 days immediately after the expiration of the 31-day period explained above.

00016

WAIVER OF PREMIUM

What is the Waiver of Premium benefit?

We will continue *Your* Basic life insurance benefit under the Policy without further payment of life insurance premium if *You* become *Totally Disabled*, provided:

1. *You* are insured under the Policy and were *Actively at Work* on or after the effective date of the Policy; and
2. *You* are under the age of 60; and
3. *You* provide *Us* with satisfactory written proof of disability within 12 months after the date *You* became *Totally Disabled*; and
4. *Your Total Disability* has continued without interruption for at least 9 months; and
5. *You* are still *Totally Disabled* when *You* submit the proof of disability; and
6. all required premium has been paid.

Total Disability or ***Totally Disabled*** means *You* are diagnosed by a *Doctor* to be completely unable because of *Sickness* or *Injury* to engage in any occupation for wage or profit or any occupation for which *You* become qualified by education, training or experience.

We will waive premium beginning the month after *We* receive satisfactory proof that *You* have been *Totally Disabled* for at least 9 months. Premium will continue to be waived provided *You*:

1. remain *Totally Disabled*; and
2. provide satisfactory written proof of continuing *Total Disability* upon request.

You are responsible for obtaining initial and continuing proof of *Total Disability*.

You will be covered for the amount of life insurance in force as of the date *Total Disability* commenced. The amount of life insurance continued in force will be subject to any reduction in benefits as shown on the Schedule of Benefits or which are the result of an amendment to the Policy, but in no event will the insurance amount increase while *Your* life insurance is continued under Waiver of Premium. This life insurance coverage will continue without the payment of premium until *You* are no longer *Totally Disabled, or* attain the Maximum Waiver of Premium Duration as set forth in the Schedule of Benefits or retire, whichever occurs first.

We may have *You* examined at reasonable intervals during the period of claimed *Total Disability*. Continuation of life insurance under the Waiver of Premium provision shall end immediately and without notice if *You* refuse to be examined as and when required.

If *You* are approved for continued coverage under the Waiver of Premium provision, *You* will be asked to name a beneficiary. That beneficiary designation:

1. will only apply while *Your* coverage continues under this Waiver of Premium provision; and
2. if different from the designation on *Your* enrollment form, shall constitute a change of beneficiary under the Policy.

We will pay the amount of life insurance in force to *Your* beneficiary if *You* die before furnishing satisfactory proof of *Total Disability*, if:

1. *You* die within one year from the date *You* became *Totally Disabled*; and
2. *We* receive proof that *You* were continuously *Totally Disabled* until the date of death; and
3. *We* receive proof of death not more than two (2) years after *Your* death.

If continuation of life insurance under the Waiver of Premium provision ceases while the Policy is still in force, and *You* are employed by the *Policyholder*, *Your* life insurance will continue provided premium payments begin on the next premium due date. If *You* return to work with the *Policyholder*, *You* must make a new beneficiary designation. If *You* do not name a new beneficiary, *We* will pay death benefits in accordance with the Facility of Payment provision.

If continuation of life insurance under the Waiver of Premium provision ceases, and *You* are no longer employed by the *Policyholder*, *You* may apply for an individual life insurance policy in accordance with the Conversion of Life Insurance provision of this Certificate.

00017

ACCELERATED DEATH BENEFIT

The benefit paid under this provision may be taxable. If so, *You* or *Your* beneficiary may incur a tax obligation. As with all tax matters, *You* or *Your* beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect *Your* eligibility for Medicaid or other governmental benefits or entitlements.

What is the Accelerated Death Benefit?

The *Accelerated Death Benefit* is a percentage of *Your* group Basic term life insurance which is payable to *You* prior to *Your* death if *We* receive *Proof* that *You* have a *Terminal Condition*. The *Accelerated Death Benefit* is limited to the maximum and minimum amounts shown on the Schedule of Benefits, and is payable only once to any one *Insured*.

The *Accelerated Death Benefit* is calculated on the group Basic term life insurance benefit amount in force under the Policy on the date *You* are diagnosed with a *Terminal Condition*.

Who is Eligible for an Accelerated Death Benefit?

This benefit only applies to *Insureds* with at least the Minimum Covered Life Insurance Benefit amounts set forth in the Schedule of Benefits. *You* must have been *Actively at Work* on or after the effective date of the Policy to be eligible for an *Accelerated Death Benefit*.

This benefit does not apply to Accidental Death and Dismemberment benefits.

Terminal Condition means *You* have been examined and diagnosed by *Your Doctor* as having a medically determined condition which is expected to result in death within 24 months or any medically determined condition which requires *Your* continuous confinement in an *Eligible Institution*, if *You* are expected to remain there until death. For the purposes of this provision, an *Eligible Institution* means a hospital, an inpatient hospice facility, or an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled nursing services, that is duly licensed by the appropriate governmental authority to provide such services.

The Accelerated Death Benefit Payment

We will pay the benefit during *Your* lifetime if *You* are diagnosed with a *Terminal Condition* if *You* or *Your* legal representative submits a claim for an *Accelerated Death Benefit* and provides satisfactory *Proof*. The benefit will be paid in one sum to *You*.

Are there any exceptions to the payment of the Accelerated Death Benefit?

The *Accelerated Death Benefit* will not be payable:

1. for any amount of group term life insurance which is less than the Minimum ADB Payment as set forth in the Schedule of Benefits; or
2. if *Your Terminal Condition* is the result of:
   a. attempted suicide, while sane or insane; or
   b. intentionally self-inflicted injury; or
3. if *Your* group term life insurance benefit has been assigned; or
4. if *Your* group term life insurance benefit is payable to an irrevocable beneficiary, including notification to Us that such benefit or a portion of such benefit is to be paid to a former spouse as part of a divorce or separation agreement.

Notice and Proof of Claim

You must elect the *Accelerated Death Benefit* in writing on a form that is acceptable to Us. *You* must furnish *Proof* that *You* have a *Terminal Condition*, including certification by a *Doctor*.

Proof under the Accelerated Death Benefit means evidence satisfactory to Us that *You* have a *Terminal Condition*. *We* reserve the right to determine, at *Our* sole discretion, if Proof is acceptable.

Effect on Insurance

The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon *Your* death. When the *Accelerated Death Benefit* is paid:

1. the term life insurance benefit otherwise payable upon *Your* death will be reduced by the amount of the *Accelerated Death Benefit*;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

00020 IL

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT (AD&D)

What is the AD&D Benefit?

If, while insured under the Policy, *You* suffer an *Injury* in an *Accident*, *We* will pay for those *Losses* set forth in the "Table of Losses" below. The amount paid will be the percentage stated in the Table of Losses but not more than the Coverage Amount set forth in the Schedule of Benefits. The *Loss* must:

1. occur within 365 days of the *Accident;* and
2. be the direct result of the *Accident*

TABLE OF LOSSES	% OF COVERAGE AMOUNT PAYABLE
Loss of Life	100%
Loss of Both Hands	100%
Loss of Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand	50%
Loss of One Foot	50%
Loss of Entire Sight of One Eye	50%
Loss of Thumb and Index Finger (on same hand)	25%

Definitions which apply to the AD&D Provision:

Accident or ***Accidental*** means an unexpected event that was not reasonably foreseeable.

Loss, with respect to hand or foot, means actual and permanent severance from the body at or above the wrist or ankle joint, as applicable. With respect to eyes, loss means entire and irrecoverable loss of sight. With respect to thumb and index finger, loss means complete severance of entire digit at or above joints.

The total amount of AD&D benefits payable for all *Losses* for any *Insured* resulting from any one *Accident* will not be greater than the Coverage Amount set forth in the Schedule of Benefits.

Except as provided in a particular AD&D benefit provision, *We* will pay benefits for loss of life to the same beneficiary(ies) named to receive life insurance benefits. Benefits for all other *Losses* will be paid to *You*.

00030 IL

SEAT BELT BENEFIT

What is the Seat Belt Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits, if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* were driving or riding in an *Automobile*, if:

1. the *Automobile* is equipped with *Seat Belts*.
2. the *Seat Belt* was in actual use and properly fastened at the time of the *Accident*.
3. the position of the *Seat Belt* is certified in the official report of the *Accident* or by the investigating officer. A copy of the police accident report must be submitted with the claim.
4. *You* were driving or riding in an *Automobile* driven by a licensed driver who was neither:

a. intoxicated or driving while impaired. Intoxication and impairment shall be determined, with or without conviction, by the law of the jurisdiction in which the Accident occurs or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication; nor
b. under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

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

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

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

00031

AIR BAG BENEFIT

What is the Air Bag Benefit?

We will pay an additional amount as set forth in the Schedule of Benefits if a benefit is payable under the AD&D Benefit for *Your* loss of life as the result of an *Accident* which occurs while *You* are driving or riding in an *Automobile* provided that:

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

If it is unclear whether *You* were properly wearing *Seat Belt*(s) or if it is unclear whether the *Air Bag* inflated properly, then the Air Bag Benefit will be $1,000.

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

00032

REPATRIATION BENEFIT

What is the Repatriation Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits, for the preparation and transportation of *Your* body to a mortuary if:

1. the Coverage Amount under the AD&D Benefit is payable for *Your* loss of life; and
2. *Your* death occurs at least 75 miles away from *Your* principal residence.

00033

EDUCATION BENEFIT

What is the Education Benefit?

We will pay an additional amount, as set forth in the Schedule of Benefits to *Your Dependent Student* if an AD&D benefit is payable for *Your* loss of life. *We* will only pay one Education Benefit to any one

Dependent Student during any one school year. If the *Dependent Student* is a minor, *We* will pay the benefit to the legal representative of the minor.

Definitions which apply to the Education Benefit:

Student means an *Eligible Dependent* child who, on the date of *Your* death, is:

1. A full-time post-high school student in a *School of Higher Education*; or
2. A student in the 12th grade but who becomes a full-time post-high school student in a *School of Higher Education* within 365 days after *Your* death.

School of Higher Education means an institution which:

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

When Benefit Ends: A *Dependent Student* will no longer be eligible to receive the Dependent Education Benefit upon the earlier of the following:

1. Our payment of the fourth installment of the Dependent Education Benefit on behalf of or to the *Dependent Student;* or
2. At the end of the period during which due Proof must be submitted if no due Proof is submitted.

Special Child Education Benefit: If *Your Eligible Dependent* child does not qualify as a *Student*, but is enrolled in an elementary or high school, *We* will pay a Child Education Benefit in the amount of $1,000. This benefit is payable once upon proof that *You* died as a result of an Accident for which the Accidental Death & Dismemberment benefit is payable and that, within 12 months after *Your* death, *Your Eligible Dependent Child* is a full-time student in an elementary or high school.

00034

LIMITATIONS

Are there any Limitations for losses due to an Accident?

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

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except an infection of an *Accidental Injury*; or
3. suicide or attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. while under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by a licensed physician and used in the manner prescribed. This limitation does not apply if the influence was involuntary or unintentional. Conviction is not necessary for a determination of being under the influence; or

7. direct result of the insured's intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Conviction is not necessary for a determination of being intoxicated; or

8. active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, with a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

We will not pay any benefit for *Loss* of life resulting from or caused by war or act of war, if the cause of death occurs while the *Insured* is serving in the military, naval or air forces of any country, combination of countries or international organization, provided such death occurs while in such forces or within six months after termination of services in such forces.

00050 IL

UNIFORM PROVISIONS

(Applicable to Dismemberment Coverage Only)

Initial Notice of Claim

We must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of the *Loss*.

Time Limit for Filing Your Claim

We must receive written proof of loss within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. However, unless the claimant is legally incapacitated, written proof of loss must be given no later than one year after the time proof is otherwise due.

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

1. It was not reasonably possible to give written proof during the one year period, and

2. Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

For the Education Benefit, proof of loss must:

1. Include proof of *Dependent Student* status; and

2. Be submitted no later than
   a. Two months after completion of course work for that particular school year if the *Dependent Student* is enrolled in a *School of Higher Education* at the time of *Your* death. School year shall be deemed to begin on September 1st and end on August 31st; or
   b. Within six (6) months after enrollment in a *School of Higher Education* if the *Dependent Student* is in the 12th grade at the time of *Your* death.

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

Physical Examination/Autopsy

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

00051

TERMINATION PROVISIONS

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

1. the date on which the Policy is terminated;
2. the date *You* stop making any required contribution toward payment of premiums;
3. the effective date of an amendment to the Policy which terminates insurance for the class to which *You* belong; or
4. the date *You*:
    a. are no longer a member of a class eligible for this insurance,
    b. request termination of coverage under the Policy,
    c. are retired or pensioned, or
    d. are no longer *Actively at Work* as a result of a disability, layoff, leave of absence, sabbatical or military leave, *You* may continue to be eligible for group insurance coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the disability began, provided all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.
Leave of Absence	Until the end of the month following the month during which the leave of absence began, provided all premiums are paid when due; or, governed by the Policyholder's Human Resource policy on family and medical leaves of absence, in accordance with the FMLA provision below.
Sabbatical	Until the end of the month following the month in which the sabbatical began, provided all premiums are paid when due.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, provided all premiums are paid when due.

If coverage terminates due to termination of employment, group insurance shall terminate at 12:00 midnight on the last day for which premium was paid.

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

00052 IL

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*.

00053

GENERAL 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 his 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 *Loss* must be filed, unless the law in the state where *You* live allows a longer period of time.

Clerical Error

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

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

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

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

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.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates.
Premium charges for increases in insurance amounts becoming effective during a policy month will begin on the next premium due date. Premium charges for insurance terminating during a policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is

for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If *You* have misstated *Your* age, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

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

Conformity with 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.

Assignment

You may assign any incident of ownership *You* may possess of the life insurance benefits provided under the Policy to anyone other than the *Policyholder*. We are not responsible for the validity or legal effect of any assignment. Collateral assignments, by whatever name called, are not permitted.

00055 IL

DEFINITIONS

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

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

1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
   a. work at the *Policyholder*'s usual place of business; or
   b. work at a location to which the *Policyholder*'s business requires *You* to travel;
3. be paid regular earnings by the *Policyholder*, and
4. not be 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*.

00061

Activities of Daily Living means:

1. Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
2. Toileting – Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.
3. Transferring – Moving into or out of a bed, chair or wheelchair.
4. Bathing – Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
5. Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
6. Continence – Ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

00062

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.

00066

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 *Your* changing from part-time to full-time, or full-time to part-time.

00068-A

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

00070

Dependent or Eligible Dependent means:

1. *Your* lawful *Spouse or Domestic Partner*; and/or
2. *Your* unmarried child who is within the age limits set forth in the Schedule of Benefits, and who is not in active military service.

Eligible Dependents Include

1. *Your* natural or step child.
2. a child placed with *You* for adoption from the date of placement or the date *You* are party in a suit in which *You* seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of *Your* child who is *Your* dependent for federal income tax purposes at the time application for coverage of the child of *Your* child is made.

00072

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

00073

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

00074

Gainful Occupation means any work or employment in which the insured *Employee*:

1. is or could reasonably become qualified, considering his or her education, training, experience, and mental or physical abilities;
2. could reasonably find work or employment, considering the demand in the national labor force; and
3. could earn (or reasonably expect to earn) a before-tax income at least equal to 60% of his or her Pre-disability Income.

00078

Hospital Confined means that, upon the recommendation of a *Doctor*, *You* are registered as an inpatient in a hospital, nursing home or other medical facility which provides skilled medical care or as an outpatient in a hospital because of surgery. *You* are not *Hospital Confined* if *You* are receiving emergency treatment or if *You* are hospitalized solely because of non-surgical medical or diagnostic test.

00081

Injury means bodily injury resulting directly from an Accident and independently of disease or bodily infirmity.

00082 IL

Insured means an Employee covered under the Policy.

00083

Male Pronoun whenever used includes the female.

00088

Material and Substantial Duties means duties that are normally required for the performance of *Your Regular Occupation* and cannot be reasonably omitted or modified.

00089

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

00097

Policyholder means the person, firm, or institution to whom the Policy was issued. *Policyholder* also means any covered subsidiaries or affiliates set forth on the face of the Policy. If the *Policyholder* is an association or a trust, the term *Participating Employer* shall be substituted for *Policyholder*.

00098

Proof under the Accelerated Death Benefit means evidence satisfactory to Us that *You* have a *Terminal Condition*. *We* reserve the sole right to determine if Proof is acceptable.

00100 IL

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

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

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

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

00104

Regular Occupation means the occupation that *You* are routinely performing when *Your* life insurance terminates due to *Disability*. *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.

00105

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

00109

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

00119

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

00120

FORT DEARBORN LIFE INSURANCE COMPANY

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

DISCLOSURE NOTICE

Accelerated Death Benefit

This benefit may be taxable. If so, the *Insured* or his beneficiary may incur a tax obligation. As with all tax matters, the *Insured* or his beneficiary should consult a personal tax advisor to assess the impact of the benefit. Receipt of this benefit may adversely affect the *Insured's* eligibility for Medicaid or other governmental benefits or entitlements.

DEFINITIONS

Accelerated Death Benefit means 50% of the *Insured's* group term life insurance amount in force on the date that *We* receive satisfactory *Proof* that such *Insured* has a *Terminal Condition*.

Proof means evidence satisfactory to *Us* that an *Insured* has a *Terminal Condition*.

Terminal Condition means an *Insured* has been examined and diagnosed by his *Doctor* as having a medically determined condition which is expected to result in his death within 24 months, or any medically determined condition which requires his continuous confinement in an *Eligible Institution,* if he is expected to remain there until death. For the purposes of this provision, an *Eligible Institution* means a hospital, an inpatient hospice facility, or an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled nursing services, that is duly licensed by the appropriate governmental authority to provide such services.

BENEFIT. *We* will pay an *Accelerated Death Benefit* during the lifetime of an *Insured* if he or his legal representative elects an *Accelerated Death Benefit* and provides satisfactory *Proof* that the *Insured* has a *Terminal Condition*. The benefit will be paid in one sum to the *Insured*. The *Accelerated Death Benefit* amount is limited to a maximum of $150,000 and a minimum of $7,500, and is payable only once to any one *Insured*. There is no cost for this benefit.

EFFECT ON INSURANCE. The *Accelerated Death Benefit* is in lieu of the group term life insurance benefit that would have been paid upon the *Insured's* death. When the *Accelerated Death Benefit* is paid:

1. the group term life insurance benefit otherwise payable upon the *Insured's* death, will be reduced by the amount of the *Accelerated Death Benefit*;
2. the amount of group term life insurance which could otherwise have been converted to an individual contract will be reduced by the amount of the *Accelerated Death Benefit*; and
3. the premium due for group term life insurance will be calculated on the amount of such insurance remaining in force after deducting the *Accelerated Death Benefit*.

This notice is a brief description of the *Accelerated Death Benefit*. For further details of coverage, including limitations, refer to the *Accelerated Death Benefit* provision in your certificate.

FORT DEARBORN LIFE INSURANCE COMPANY
(herein called FDL)
Chicago, Illinois

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

AMENDATORY RIDER

This rider amends the *Policy* or Certificate to which it is attached. It takes effect and ends at the same time as the *Policy* or Certificate. All provisions of the *Policy* or Certificate will apply to this rider, except that in the event of a conflict, the specific provisions of this rider will govern.

The following benefit is added:

Loss of Use Benefit

What is the Loss of Use Benefit?
If, while insured under the *Policy*, *You* suffer a Loss of Use in an *Accident*, which results in a condition listed in the "Table of Losses" below, *We* will pay for those losses as set forth in the "Table of Losses". The Loss of Use Benefit is calculated from the *Employee* Benefit Amount shown on the Schedule of Benefits. The Loss of Use must:

1. occur within 365 days of the *Accident;* and
2. be the direct result of the *Accident.*

TABLE OF LOSSES	% OF COVERAGE AMOUNT PAYABLE
Quadriplegia	100%
Paraplegia	75%
Loss of Speech	50%
Loss of Hearing (both ears)	50%
Hemiplegia	50%
Uniplegia	25%

Definitions which apply to the Loss of Use Benefit:

Accident or ***Accidental*** means an unexpected event that was not reasonably foreseeable.

Hemiplegia means total *Paralysis* of one arm and one leg on the same side of the body.

Loss of Speech means entire and irrecoverable loss of speech.

Loss of Hearing means entire and irrecoverable loss of hearing in both ears.

Paralysis means loss of use without severance of a limb as a result of an *Injury* to the Spinal Cord, which has continued for 12 months. *Paralysis* must be determined by a *Doctor* to be permanent, total and irreversible.

Paraplegia means total *Paralysis* of both legs.

Quadriplegia means total *Paralysis* of both arms and both legs.

Uniplegia means total *Paralysis* of one limb.

Any claim for the Loss of Use Benefit will be in addition to any other payments afforded under this *Policy*.

LIMITATIONS

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

1. any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or;
2. any infection, except an infection which results directly from an *Accidental Injury*; or
3. attempted suicide, while sane or insane; or
4. any intentionally self-inflicted *Injury*; or
5. travel or flight in a non-commercial aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or
6. the *Insured* being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless the controlled substance was prescribed for the *Insured* by a licensed physician and the *Insured* used the controlled substance in the manner prescribed. This limitation does not apply if the ingestion of the controlled substance by the *Insured* was involuntary or unintentional. Criminal conviction is not required for *Us* to make a determination that the *Insured* was under the influence; or
7. direct result of the *Insured's* intoxication as defined by the laws of the jurisdiction in which the *Accident* occurred or .08% blood alcohol content if the jurisdiction in which the *Accident* occurred does not define intoxication. Criminal conviction is not required for *Us* to make a determination that the *Insured* was intoxicated; or
8. the *Insured's* active participation in a *Riot*. ***Riot*** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

UNIFORM PROVISIONS

(Applicable to Loss of Use Benefit Only)

Initial Notice of Claim

We must receive written notice of *Loss* within 30 days of the date of *Loss*, or as soon as reasonably possible. The *Policyholder* can assist with the appropriate telephone number and address of *Our* Claim Department. Notice may be sent to *Our* Claim Department at the address shown on the claim form or given to *Our* Agent.

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 loss and commencement of legal actions shall apply to notice and proof filed by telephone or other means acceptable to *Us*.

Claim Forms

Within 15 days of *Our* being notified in writing of a claim, *We* will supply the claimant with the necessary claim forms. The claim forms are to be completed and signed by the claimant, the *Policyholder* and the claimant's *Doctor*. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of the *Loss*.

Time Limit for Filing Proof of Loss for Your Claim

We must receive written proof of loss within 90 days after the date a *Loss* is incurred. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. How*e*ver, unless the

claimant is legally incapacitated, written proof of loss must be given no later than one year after the time proof is otherwise due.

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

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

Physical Examination/Autopsy

Upon receipt of a claim, *We* may examine an *Insured*, at *Our* expense, at any reasonable time.

ALL PROVISIONS OF THE POLICY OR CERTIFICATE WILL APPLY TO THIS RIDER, EXCEPT THAT IN THE EVENT OF A CONFLICT, THE SPECIFIC PROVISIONS OF THIS RIDER WILL GOVERN.

Except for the above, this rider does not change the *Policy* in any way.

Fort Dearborn Life Insurance Company

President

Administrative Office: 1020 31st Street
Downers Grove, Illinois 60515

FORT DEARBORN LIFE INSURANCE COMPANY
Chicago, Illinois

AMENDATORY ENDORSEMENT

This Amendatory Endorsement amends the Policy or Certificate to which it is attached. It takes effect and ends at the same time as the Policy or Certificate to which it is attached. All provisions of the Policy or Certificate will apply to this Amendatory Endorsement, except that in the event of a conflict, the specific provisions of this Amendatory Endorsement will govern.

The term **Spouse**, wherever it appears in the Policy or Certificate, is amended as follows:

Spouse includes a **Party to a Civil Union**.

In addition to civil unions entered into under Illinois law, the term **Civil Union** includes a marriage between persons of the same sex, a civil union, a domestic partnership, or a substantially similar legal relationship, other than common law marriage, legally entered into in another jurisdiction.

President

Nothing contained in this Amendatory Endorsement shall be held to alter or affect any provision or condition of the Policy or Certificate, other than as stated above.

Administrative Office: 1020 31st Street
Downers Grove, Illinois 60515

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

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amount of coverage.

The Association was established to provide protection in the unlikely event that your member 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 Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*****
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*****The maximum amount of protection for each individual, regardless of the number of policies or contracts, in $300,000, except special rules apply with regard to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

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 residency requirements and other limitations under Illinois law.

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

Illinois Life and Health *Insurance Guaranty Association* *8420 West Bryn Mawr Avenue, Suite 550* *Chicago, Illinois 60631-3404* *(773) 714-8050*	*Illinois Department of Insurance* *4th Floor* *320 West Washington Street* *Springfield, Illinois 62767* *(217) 782-4515*

Insurance companies and agents are not allowed by Illinois 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 an inconsistency between this notice and Illinois law, then Illinois law will control.

Administrative Office: 1020 31st Street
Downers Grove, Illinois 60515

ERISA INFORMATION STATEMENT*

The benefits described in your certificate are insured by a Policy issued by Fort Dearborn Life Insurance Company ("FDL"), pursuant to an Employee Welfare Benefit Plan (" the Plan") established by your employer ("the Company"). This ERISA Information Statement ("EIS") describes some of the key provisions of the Plan in effect as of the Effective Date of the Policy.

It is not the intention of the EIS to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the EIS or in the event of any conflict between the EIS and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from this EIS.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of 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 FDL and shall be effective as of the date agreed to, in writing by the Plan Sponsor and FDL. 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. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company. FDL's (the Insurer's) services shall be limited to, and the Plan Administrator has the full and final authority to:

- 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

* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

Plan fiduciary, to the extent provided in ERISA Section 405(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

B. CLAIMS PROCEDURE:

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form in writing. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist FDL in the claims processing for this Plan or by contacting FDL directly at:

Claims Department

Fort Dearborn Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-778-2281

For the purpose of this Section, including Subsections 1 and 2 below, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If FDL uses electronic notices, it will do so in accordance with 29 CFR 2520.104b- 1©(i), (iii) and (iv).

1. Disability Insurance Plans

FDL 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, FDL notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If the extension is due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

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

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

You may:

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

* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

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.

FDL 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, FDL notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

2. Life Insurance Plans

FDL will give you a decision no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, the claimant will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed; and
- the steps that have to be followed to have the claim reviewed.

Any denied claim may be appealed to the Insurer for a full and fair review. The claimant may:

a) request a review upon written application within 60 days of receipt of claim denial;
b) upon request and free of charge, review pertinent documents, records and other information relevant to the claim and receive copies of same; and
c) submit issues, comments, records, and other information in writing.

A decision will be made by the Insurer no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based. The decision will advise you of any other appeal rights you have under the Plan, as well as your right to bring an action under Section 502(a) of ERISA.

C. ERISA NOTICE OF YOUR RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the 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.

* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

No one, including your employers, your union, or any other persons, 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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a 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 federal court. The court will decide who should pay 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, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.

* If this Plan is an ERISA plan, these ERISA provisions apply. However, your employer may issue a Summary Plan Description ("SPD"). If it does, and if there are any conflicts between the SPD and the EIS in regards to your ERISA rights, the SPD provisions will always control.

Administrative Office:
1020 31st Street
Downers Grove Illinois 60515

Principal Office:
300 E. Randolph Street
Chicago Illinois 60601