Short-Term Disability Benefits

Employee Summary Plan Description (SPD)

BlueCross BlueShield of Texas

Group Name: BWC TERMINAL HOLDINGS, LLC

Group Number: F023298-0001

Advice to Pay (ATP)

03/31/2023

Benefit Booklet
Group Short Term Disability Plan

Group Name:BWC TERMINAL HOLDINGS, LLC

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Advice to Pay (ATP)

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

***Employer*:**	BWC TERMINAL HOLDINGS, LLC
Group Number:	F023298-0001
Plan Effective Date:	January 1, 2019 - Revised: April 1, 2023
Plan:	Short Term Disability Plan
Eligible Class:	All active full-time *Employees* who have completed the *Waiting Period* and are *Actively at Work* for the *Employer* are eligible for participation. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Employer*. Part-time, seasonal and and temporary employees are not eligible.
Eligibility *Waiting Period*:	**Current Employees** None **New Employees** Date of Hire
***STD Weekly Benefit*:**	60% - 100% according to length of service, with No Maximum Weekly Benefit.

Length of Service	**Weeks of 100% Pay**	**Weeks of 60% Pay**
Less than 6 months	0	0
6 months to 1 year	2	24
1 but less than 2 years	4	22
2 but less than 3 years	8	18
3 but less than 4 years	12	14
4 but less than 5 years	18	8
Over 5 years	26	0

***Elimination Period*:**	5 Consecutive Working Days - *Injury* 5 Consecutive Working Days - *Sickness*
Day Benefits Begin:	Day 6 of Disability due to *Injury* Day 6 of Disability due to *Sickness*
Maximum Period Payable	26 Weeks following the *Elimination Period* or until benefits become payable under the Long Term Disability plan, whichever occurs first

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible to participate in this Plan?

All *Employees* who belong to an eligible class and work the minimum number of hours as set forth in the *Schedule of Benefits* in this booklet are eligible. An *Employee* must be *Actively at Work* to be eligible.

When does *Your* participation in the Plan become effective?

If *You* are an eligible *Employee*, *Your* participation will become effective on the date indicated in the *Schedule of Benefits*, provided *You* are *Actively at Work* on that day.

You must be *Actively at Work* for your participation to become effective.

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

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

Your effective date for any initial participation 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*.

Who pays for *Your* participation?

The *Employer* pays the entire cost for *Your* participation.

Eligibility after *You* Terminate Employment

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

Exception: If *Your* participation ends due to termination of employment and *You* return to *Active Work* in an eligible class within 6 months, *You* will not be subject to a new Eligibility *Waiting Period*.

SHORT TERM DISABILITY BENEFITS

How is *Disability* defined?

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

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

How is *Total Disability* defined?

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

How is *Partial Disability* defined?

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

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

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

Loss of Professional License or Certification

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

What is the *Elimination Period* and how is it satisfied?

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

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

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

Can *You* satisfy *Your Elimination Period* if *You* are working?

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

What *Disability* Benefit are *You* eligible to receive?

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

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

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

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

Your STD Weekly Benefit will be based on *Your Weekly Earnings* as reported by *Your* Employer. An *STD Weekly Benefit* will be payable after the end of the *Elimination Period* if *You* are *Disabled*.

Your Net STD Weekly Benefit amount will be calculated as follows:

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

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

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

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

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

Can *You* work and still receive benefits?

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

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

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

The Work Incentive Benefit/Partial Disability Benefit will be the lesser of:

1. the Maximum Weekly Benefit shown in the Schedule of Benefits; or
2. the Employee's Pre-disability Earnings minus his Partial Disability income.

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

What are the Deductible Sources of Income?

Your Gross STD Weekly Benefit will be reduced by:

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

      Denial of Workers' Compensation will not result in the payment of benefits under the Plan if *Your Disability* resulted from an occupational *Sickness* or *Injury*. Benefits are also not payable under the Plan if *You* are entitled to participate in Workers' Compensation and choose not to do so.
2. Retirement benefits paid under the Social Security Act including any amounts for which *Your* dependents may qualify because of *Your* retirement;

3. Retirement and *Disability* benefits paid under a Retirement Plan provided by the Plan Sponsor except for amounts attributable to *Your* contributions;
4. *Disability* benefits paid under any No Fault Auto Motor Vehicle coverage;
5. Amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, not to exceed 50% of the net settlement.

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

Proration of Lump Sum Awards

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

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

What other sources of income are not deductible?

Your Gross STD Weekly Benefit under the Plan will not be reduced by any of the following:

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

What happens if *Your* Deductible Sources of Income increase?

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

How long will *You* receive benefits?

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

1. the date this Plan terminates;
2. the date this Plan no longer available for *Your* class;
3. the date *You* are no longer *Disabled*;
4. the end of the *Maximum Period Payable*;
5. the date on which *You* return to work for the *Employer* in any capacity, unless as part of the *Work Incentive Benefit;*
6. the date on which *You* begin to receive benefits under any retirement plan sponsored by the *Employer*; or
7. the date *You* die.

What happens if *Your Disability* recurs?

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

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

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

Disability must recur while *You* are participating in the Plan.

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under the Plan?

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

1. loss of professional license, occupational license or certification;
2. ommission of, participation in, or an attempt to commit an assault or felony;
3. Intentionally self-inflicted injuries;
4. attempted suicide, regardless of mental capacity;
5. *Cosmetic Surgery* except when required due to Injury or Sickness;
6. Occupational *Injury* or *Sickness*;
7. participation in a war, declared or undeclared, or any act of war.

Furthermore:

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

TERMINATION OF PLAN PARTICIPATION

When will *Your* participation in the Plan terminate?

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

1. the date on which the Plan is terminated; or
2. the date *You* stop making any required contribution toward payment of premiums, if applicable; or
3. the date *You*:
    a. are no longer a member of a class eligible to participate, or
    b. are retired or pensioned, or
    c. are no longer *Actively at Work* because of a leave of absence, furlough, layoff, or temporary work stoppage due to a labor dispute.

If *You* are no longer *Actively at Work* as a result of layoff or leave of absence and you are *Totally Disabled* on the date layoff or leave of absence begins, We will pay disability benefits up to the maximum period set forth in the *Schedule of Benefits*.

Termination of the Plan will not affect *Your* claim for a loss which began while the Plan was in force.

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

You should notify the Claims Administrator of *Your* claim as soon as possible, so that the Claims Administrator may make a timely decision on *Your* claim. *Your Employer* can assist *You* with the appropriate telephone number and address of the Claims Administrator's Claim Department. *You* must send the Claims Administrator written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to the Claim Department at the address shown on the claim form.

Telephonic Claim Notification

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

Time Limit for Filing *Your* Claim

You must furnish the Claims Administrator with written proof of loss within 30 days after *Your* last day worked.

Proof of *Disability*

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

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

Continuing Proof of *Disability*

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

Examination

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

Authorization and Documentation *You* will be asked to supply

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

Time of Payment of Claim

As soon as the Claims Administrator has all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid at least as frequently as once every two weeks, as long as *You* continue to qualify for it.

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

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

Can *You* assign *Your* benefits?

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

What will happen if a claim is overpaid*?*

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

The Plan has the right to recover from *You* any amount that is an overpayment of benefits under the Plan. *You* must refund to the Plan the overpaid amount. The Plan may also, without forfeiting its right to collect an overpayment through any means legally available, recover all or any portion of an overpayment by reducing or withholding future benefit payments.

In an overpayment situation, the Plan Administrator will determine the method by which the repayment is made. *You* will be required to sign an agreement which details the source of the overpayment, the total amount that will be recovered and the method of recovery.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Date of Disability means the date the Claims Administrator determines that You are Disabled.

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

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

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

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

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

Employer means the person, firm, or institution named in the *Schedule of Benefits*, including any covered subsidiaries or affiliates named in the *Schedule of Benefits*.

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

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

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

Hospital means either of the following:

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

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

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

Male pronoun, whenever used, includes the female.

Material and Substantial Duties means duties that:

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

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

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

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

Regular Occupation means the occupation that *You* are routinely performing when *Your Disability* begins. The Claims Administrator 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 *Employer* or at a specific location.

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

Sickness means sickness or disease causing *Disability* which begins while *You* are participating in the Plan.

Spouse means lawful *Spouse*.

STD means Short Term Disability.

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

Waiting Period as shown in the *Schedule of Benefits* means the continuous length of time immediately before *Your* Effective Date during which You must be in an Eligible Class.

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

commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than *Your* Employer.

You, Your and ***Yours*** means the *Employee* to whom this Benefit Booklet has been issued.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Dearborn Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Regulatory Inquiry Representative at 1-630-691-0365
Toll-free: 1-877-442-4207
Email: DOIComplaintsTX@bcbstx.com
Mail: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call: 1-800-252-3439
Online: www.tdi.texas.gov
Email:
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Dearborn Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Regulatory Inquiry Representative at 1-630-691-0365
Teléfono gratuito: 1-877-442-4207
Correo electrónico: DOIComplaintsTX@bcbstx.com
Dirección postal: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714

END OF BENEFIT BOOKLET

STATEMENT OF ERISA RIGHTS

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

1. Receive Information about Your Plan and Benefits

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

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

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

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

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

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The short term disability benefits described in your Benefit Booklet are provided pursuant to an "employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") established by your employer ("the Company").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a plan administrator. Your plan administrator has delegated the authority to administer claims under the Plan to Blue Cross and Blue Shield of Texas. The Claims Administrator will make decisions concerning eligibility and benefit determinations in accordance with the Plan provisions.

A. ADMINISTRATION OF THE PLAN

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

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

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person.

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 administrator shall, with respect to the Plan:

- 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 Plan and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

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

B. CLAIMS PROCEDURE:

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must follow the claim procedures described in your Benefit Booklet by submitting the proper form in writing to the Claims Administrator at:

Claims Department

Dearborn Life Insurance Company

701 E. 22nd Street

Lombard, IL. 60148

1-800-721-7987

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 the Claims Administrator uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

The Claims Administrator 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, the Claims Administrator 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 Plan provision(s) 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 you have to follow to have the claim reviewed.

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

You may:

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

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

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

The Claims Administrator will make a decision no more than 45 days after it receives your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Claims Administrator 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 decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision(s) on which the decision is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
- a statement of the claimant's right to bring action under section 502(a) of ERISA.