Weekly Income Benefits

Employee Benefit Booklet

dearborn national™

STOCKBRIDGE COMMUNITY SCHOOLS

M02384-0001

Class 1-03

Dearborn National® Life Insurance Company

Dearborn National Life Insurance Company
(A stock life insurance company)
Administrative Office: 1020 31st Street
Downers Grove, IL. 60515-5591

Certifies that the holder of this Certificate, while entitled to insurance, is subject to all the terms and conditions contained in the Policy.

For all purposes of this Certificate, the Insured will be referred to as "you" or "your", and Dearborn National Life Insurance Company will be referred to as "we", "our" or "us".

THIS CERTIFICATE OF INSURANCE IS NOT AN INSURANCE POLICY.. It does not form a part of the Policy, nor does it amend, extend or alter the coverage provided by the Policy. In case of a dispute, you should refer to the language contained in the Policy.

IF YOU SHOULD CEASE ACTIVE WORK FOR ANY REASON, please consult your Employer immediately to determine what arrangements may be made to continue your insurance benefits.

William R Barnes
Secretary

President

Group Health Insurance Certificate - Weekly Income
Non-Participating

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

POLICYHOLDER: STOCKBRIDGE COMMUNITY SCHOOLS

POLICY NUMBER: M02384-0001

MASTER POLICY EFFECTIVE DATE: As shown in the Master Application

CLASS OF INSUREDS	DEFINITION
1-03	All active full-time Custodial & Maintenance employees.

Weekly Income Benefit Amount: 60% of your Basic Weekly Salary* rounded to the nearest dollar to a maximum of $100.

*Basic Weekly Salary means your earnings in effect from your Employer based on a normal work week not exceeding (forty) 40 hours. It does not include bonuses, overtime pay, extra compensation or commissions.

Day Benefits Begin: Injury: 91st Day
Sickness: 91st Day
Hospital Confined: 91st Day

Maximum Benefit Period: 26 Weeks

DEFINITIONS

"Actively at Work" and **"Active Work"**—the active full-time performance of all of the customary duties of your occupation at the Employer's usual place of business or place(s) that the Employer's normal course of business requires.

"Application"—the Policyholder's written Application for insurance under the Policy.

"Basic Weekly Salary"—your earnings in effect from your Employer for your normal work week not exceeding forty (40) hours. It does not include bonuses, overtime pay, extra compensation or commissions

"Contributory"—insurance for which you are required to pay all or part of the Premium.

"Disabled" and "Disability"—you: (a) are unable because of Injury or Sickness, to perform the substantial and material duties of your regular occupation; (b) are under the regular care of a licensed Physician; and (c) are not gainfully employed in any occupation reasonably consistent with your education, training and experience.

"Date of Eligibility"—the date that a person, as part of an eligible class of persons, becomes eligible for insurance under the Policy. The Application for the Policy contains the requirements for eligibility.

"Effective Date"—the date the insurance applied for becomes effective.

"Employer"—the entity through which a Policyholder makes insurance, under the Policy, available.

"Full-Time Employee"—an active 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 working the minimum hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

"Evidence of Insurability"—any medical or other information required, by us, to determine that a proposed Insured is acceptable for insurance.

"Injury"—bodily Injury resulting directly from an accident and independently of all other causes. The Injury must occur and Disability must begin while a person is insured under the Policy. Any Disability which begins more than 14 days after the date of an accident causing an Injury will be considered a Sickness for the purpose of determining benefits under the Policy.

"Noncontributory"—insurance for which the Insured is not required to pay any of the Premium.

"Physician"—a licensed practitioner, practicing within the scope of his/her license. A Physician must be someone other than you or your family member.

"Policy"—the Policy on which the provisions of this Certificate are based.

"Policy Anniversary"—the same month and day as the Effective Date for each succeeding year the Policy remains in force or any other date upon which we and the Policyholder have agreed.

"Policyholder"—the group to whom the Policy is issued and who is named as Policyholder in the Schedule of Benefits.

"Premiums"—money paid by the Policyholder, you or partly by both for this insurance.

"Sickness"—illness or disease causing Disability while a person is insured under the Policy.

Disabilities resulting from Complications of Pregnancy are insured on the same basis as any other covered Sickness. "Complications of Pregnancy" means pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management.

"Waiting Period"—a period stated in the Application for the Policy which immediately follows the employment date and during which time a person in an eligible class has to wait before becoming eligible for insurance.

GENERAL PROVISIONS

ELIGIBILITY. The Application for the Policy states the eligibility requirements, including Classification, Exclusions, Date of Eligibility and Waiting Period. A person must be Actively at Work to be considered eligible.

YOUR EFFECTIVE DATE.

(a) If insurance is Noncontributory, insurance shall become effective on the Date of Eligibility.

(b) If insurance is Contributory, insurance shall become effective:

(i) on the date a person becomes eligible, provided that person applies for insurance on or before the Date of Eligibility and agrees to pay the required contribution; or

(ii) on the date of request for insurance, if a person's request is made within the 31 day period after the Date of Eligibility and he agrees to pay the required contribution.

A request for insurance may be made by a person more than 31 days after the Date of Eligibility or a request may be made after insurance lapses because of failure to pay the required contribution when due. In these cases, the requesting person must:

(i) furnish Evidence of Insurability acceptable to the Company; and

(ii) agree to pay the required contribution.

(c) The following apply to both Noncontributory and Contributory insurance:

(i) When Evidence of Insurability is required, insurance shall become effective on the first day of the insurance month which is the same as or which next follows the date we determine Evidence of Insurability to be acceptable.

(ii) If a person is not Actively at Work on the day prior to the date when he/she would otherwise become insured, insurance will become effective on the date of return to Active Work.

(iii) A person will be deemed Actively At Work on each day of paid vacation or scheduled day off on which he/she is not totally disabled, if he/she was Actively at Work on his/her last scheduled working day.

(iv) All requests for insurance are subject to our approval and must be made to the Policyholder in writing, on a form furnished by us.

CHANGES IN AMOUNTS OF INSURANCE/CLASSIFICATION. A change in the amount of insurance due to a change in your classification shall become effective on the date you become eligible for the change, as set forth in the Application if:

(a) you are Actively at Work; and

(b) you make the required contribution, if any, toward the premium payment.

If you are not Actively at Work on the day you would otherwise be eligible for the change, the change shall become effective on the date you are again Actively at Work.

TERMINATION OF YOUR INSURANCE. Your insurance shall cease on the earliest of the following dates.

(a) the date the Policy ends;

(b) if insurance is Contributory and you fail to make the required contribution, the insurance shall terminate at the end of the period for which contribution has been made:

(c) if the Policyholder fails to pay Premiums the insurance shall terminate at the end of the period for which Premium has been paid;

(d) upon termination of your membership in the class or classes eligible for insurance;

(d) the date your employment with the Employer ends. For purposes of the Policy, your employment will end when you are no longer actively working for the Employer.

The Policyholder may, at his option, continue insurance for you if you are not at work due to Disability if the Policyholder continues making premium payments for you.

Termination of the Policy for any cause shall be without prejudice to any claim arising prior to termination.

BENEFIT PROVISIONS

PAYMENT OF BENEFITS. The Policy applies only to losses which are incurred while you are covered under the Policy, unless otherwise provided.

Benefits payable by us for a Disability resulting from any one Sickness or Injury will be limited to the coverage provided by the Policy on the date loss commenced.

FREQUENCY OF BENEFIT PAYMENT. The benefit payable is as shown in the Schedule of Benefits, but is subject to receipt of any proof of continued loss as required by the Company. Benefits will be paid bi-weekly. All benefits are payable to you. If any such benefits remain unpaid at your death, or if you are incapable of giving a valid release for payment of any benefit, we shall have the option of paying the benefit to any one or more of the following relatives: your spouse; your parent(s); your child(ren). brother(s); or sister(s). Any payment made under this provision will completely discharge us from further obligation for the amount paid. We will not be responsible as to the application of such payment. Subject to due proof of loss any unpaid balance remaining at the termination of the Company's liability will be paid immediately.

NOTICE AND PROOF OF CLAIM. Written notice of claim must be given to us within 20 days of loss. When we receive notice of claim, forms for filing proof of claim will be furnished. If these forms are not furnished within 15 days from the time notice is received by us, you will have met the proof of loss requirement if written proof of loss is submitted within the time required.

Written proof of claim must be given to us within 90 days after loss. If proof of claim is not given within 90 days, the claim will not be denied or reduced if, that proof was given as soon as reasonably possible. "Proof" as used in this paragraph means proof satisfactory to us.

STANDARD PROVISIONS

ASSIGNMENT. Neither the benefits provided by the Policy nor the interest under ownership of the Policy are assignable.

INCONTESTABILITY. In the absence of fraud, all statements made by the Policyholder or you will be deemed representations and not warranties. No such representations will void the insurance or be used to deny a claim unless a copy of the instrument containing such representations is or has been furnished to you.

The validity of the Policy will not be contested, except for non-payment of Premium, after the Policy has been in force for at least two consecutive years from its Effective Date. No statement made by you will be used to contest the validity of the insurance with respect to the statement which was made, after such insurance has been in force for two consecutive years during your lifetime nor unless it is contained in a written application signed by you.

CHANGES. The Policy may be amended or changed at any time by written agreement between the Policyholder and us. Only an officer of Dearborn National may change, amend, alter or waive in any manner the provisions of this Policy, and then only in writing and signed by the officer.

MISSTATEMENT OF AGE. If your age has been misstated, the Premium may be adjusted. If the amount of insurance would be affected by such misstatement, it will be changed to the amount you would have had at the corrected age.

EXAMINATION. We, at our own expense, will have the right to have a Physician we designate examine you as often as we may require whenever your loss is a basis of claim.

ACTION AGAINST COMPANY. No lawsuit or action may be brought to recover on the Policy within 60 days after written proof of loss has been given. No lawsuit or action may be brought after three years from the time written proof of loss is required to be given.

WORKMEN'S COMPENSATION NOT AFFECTED. The Policy is not in lieu of and does not affect, any requirement for coverage by Workmen's Compensation insurance.

CHOICE OF HOSPITAL AND PHYSICIAN. You shall have free choice of any legally constituted hospital and any legally qualified Physician.

TERMS OF POLICY CONFORMED TO STATUTE. If any part of the Policy is contrary to the laws of the state in which it is issued, that part is hereby amended to conform to the minimum requirements of such laws.

ENTIRE CONTRACT. The Policy, the Application made by the Policyholder and the individual applications, if any, form the entire contract between the parties.

DISABILITY BENEFIT PROVISIONS

If you, while insured under the Policy, become Disabled, we will pay a disability benefit to you. The Schedule of Benefits contains:

(a) the day benefits begin;

(b) the benefit;

(c) the Maximum Benefit Period.

RECURRING DISABILITY

Successive periods of Disability, due to the same or related cause, occurring while the Policy is in force, shall be considered one period of Disability unless:

(a) separated by a return to Active Work, for a period of at least 14 days, after complete recovery from the Injury or Sickness causing the previous Disability; or

(b) unless the subsequent Disability is due to causes entirely unrelated to the causes of the previous Disability.

PARTIAL BENEFIT PERIODS. For any period of Disability less than a full calendar week, the benefits payable shall be calculated by dividing the weekly benefit by 7 and multiplying the quotient by the number of days of Disability.

EXCLUSIONS

The insurance under the Policy does not apply to:

(a) Disability due to Injury or Sickness arising out of or in the course of any employment for wage or profit; or

(b) Disability for which you are entitled to benefits under any Workers' Compensation or similar law; or

(c) Disability for any period during which you are not being regularly treated by a Physician; or

(d) Disability due to any intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane or the voluntary taking of any drug unless taken as prescribed by a Physician; or

(e) Disability due to bodily Injury as a result of the commission of or an attempt to commit an assault or felony.

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, 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 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 administrator.

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

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The benefits described in your certificate are insured by a disability policy ("Policy") issued by Dearborn National Life Insurance Company ("Dearborn National" or "Insurer"), pursuant to an "employee welfare benefit plan" ("the Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") 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 Policy to Dearborn National. As claims administrator, Dearborn National will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

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

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

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

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

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

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a). 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 follow the claim procedures described in your Group Insurance Certificate by submitting the proper form in writing to Dearborn National at:

Claims Department

Dearborn National Life Insurance Company
1020 31st Street
Downers Grove, IL. 60515-5591
1-800-348-4512

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 Dearborn National uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1©(i), (iii) and (iv).

1. Disability Insurance Plans

Dearborn National 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, Dearborn National 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;

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

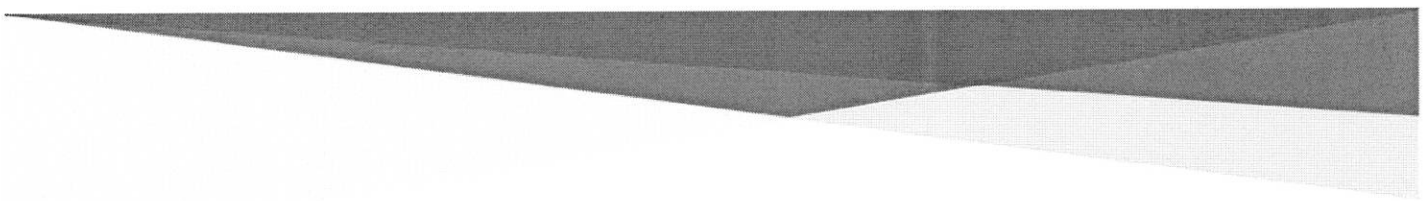
c. submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Dearborn National 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, Dearborn National 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 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;
- a statement of the claimant's right to bring action under section 502(a) of ERISA;
- 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 the decision 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; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as medication. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."



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