



Rochester Institute of Technology

Your Group Long Term Disability Plan

Policy No. 44322.005

Underwritten by First Unum Life Insurance Company

03-2007

TABLE OF CONTENTS

CERTIFICATE OF COVERAGE 1

SYNOPSIS 2

PLAN OUTLINE 3

TERMS YOU SHOULD KNOW 5

ENROLLMENT AND DATE INSURANCE STARTS 9

DISABILITY 11

RECURRENT DISABILITY 14

SURVIVOR BENEFIT 14

GENERAL EXCLUSIONS 14

PRE-EXISTING CONDITION EXCLUSION 14

MENTAL ILLNESS LIMITATION 15

PENSION PLAN CONTRIBUTION 15

CONTINUITY OF COVERAGE UPON TRANSFER OF
INSURANCE CARRIERS 16

TERMINATION 17

SOME GENERAL INFORMATION TO KNOW 18

CERTIFICATE OF COVERAGE

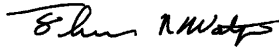
First Unum Life Insurance Company (referred to as "we," "our" and "us") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for insurance and you become and remain insured. Keep it in a safe place.

A few words about this certificate of coverage.....

We have written it in plain English. But a few terms and provisions are written as required by insurance law. You will want to read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.



President

SYNOPSIS

The insurance evidenced by this certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.

EXCLUSIONS

General Exclusions: see page 14.

Pre-existing Condition Exclusion: see page 14.

LIMITATIONS

Mental Illness Limitation: see page 15.

PLAN OUTLINE

Description of Eligible Classes

- Class 1 All full-time employees, excluding Executives, who do not elect Class 2 coverage
- Class 2 All full-time employees, excluding Executives, who elect 70% to \$7,000 coverage

Amount of Insurance

Class 1

- The lesser of:
 - 60% of basic monthly earnings; or
 - 60% of basic monthly earnings less other income benefits; or
 - the maximum monthly benefit.

Note: This benefit is subject to reductions for earnings as provided in the section titled "How is the benefit figured?"

- The maximum monthly benefit is \$5,000.

Class 2

- 70% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit, less other income benefits.

Note: This benefit is subject to reductions for earnings as provided in the section titled "How is the benefit figured?"

- The maximum monthly benefit is \$7,000.

All Classes

- The minimum monthly benefit is the greater of:
 - \$100.00; or
 - 10% of the monthly benefit before deductions for other income benefits.

Maximum Benefit Period

| Age at Disability | Maximum Benefit Period |
|-------------------|---------------------------------------|
| Less than age 60 | To age 65 but not less than 60 months |
| 60 | 60 months |
| 61 | 48 months |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 and over | 12 months |

Elimination Period: 180 days

Minimum Requirement for Active Employment:

Full-time Employees in the Retirement Transition Program: Employees must be scheduled to work at least 750 hours per year.

All Full-time Employees not eligible in another group: Employees must be scheduled to work at least 1500 hours per year.

Definition of Basic Monthly Earnings

"Basic monthly earnings" means 1/12th of your basic annual salary as of January 1st of the year in which disability begins.

In the event of an approved change in enrollment status, "basic monthly earnings" will mean 1/12th of your basic annual salary for the approved position.

An approved change in employment means you have made an application and the application has been approved by the Personnel Department.

Waiting Period:

- If you were in an eligible class on or before the policy effective date: First of the month following date of hire
- If you entered an eligible class after the policy effective date: First of the month following date of hire

Contributions

Class 1

- The cost of your insurance is paid entirely by your employer.

Class 2

- The cost of your insurance is paid entirely by you.

Changes Effective

Subject to the delayed effective date exceptions, changes in insurance take effect immediately.

Continuation of Your Insurance During Certain Absences

Type of Absence
Personal Leave of Absence

Time Limit
For up to 3 months following the date the leave of absence begins.

Authorized Professional Development Leave of Absences for an advanced degree or for active work in the field of education or research.

For up to 24 months following the date the leave of absence begins.

TERMS YOU SHOULD KNOW

Many terms used in your certificate of coverage have special meanings. A list of these terms and meanings follows:

- "Active employment" means you must be working:
 1. for your employer on a full-time basis and paid regular earnings (temporary or seasonal employees are excluded);
 2. at least the minimum number of hours shown in the plan outline; and either
 3. at your employer's usual place of business; or
 4. at a location to which your employer's business requires you to travel.
- "Basic monthly earnings" - as defined in the plan outline.
- "Disability" or "disabled" - see the end of these terms.
- "Disability benefits," when used with the term retirement plan, means money which:
 1. is payable under a retirement plan due to disability as defined in that plan; and
 2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as explained in this certificate of coverage.)
- "Eligibility date" means the date you become eligible for insurance after completing the waiting period shown in the plan outline.
- "Elimination period" means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the plan outline and begins on the first day of disability.

Note: If disability stops during the elimination period for any 30 (or less) days, then the disability will be treated as continuous. But days that you are not disabled will not count toward the elimination period.

- "Employer" means the policyholder and includes any division, any subsidiary or any affiliated company named in the policy.
- "Enrollment period" means the initial enrollment period or any annual enrollment period.
- "Evidence of insurability" means a statement or proof of your medical history upon which we will determine your acceptance for insurance.
- "Gross monthly benefit" means your benefit amount before any reduction for other income benefits and earnings.
- "Home office" means First Unum Life Insurance Company, 99 Park Avenue, New York, New York 10016.
- "Indexed pre-disability earnings" means your basic monthly earnings in effect just prior to the date your disability began adjusted on the first anniversary of benefit payments and each following anniversary. Each adjustment will be based on the lesser of 10% or the current annual percentage increase in the Consumer Price Index.

Note: The Consumer Price Index (CPI-W) is published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

- "Initial enrollment period" means one of the following periods during which you may first make written application for coverage under the policy:
 1. if you are eligible for insurance on the policy effective date, a period before the policy effective date set by your employer and us.
 2. if you become eligible for insurance after the policy effective date, the period which ends 31 days after your eligibility date.
- "Injury" means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur while you are insured and disability must begin within 30 days of the injury. But any disability which begins after the policy terminates will not be covered if you become eligible for coverage under any other group long term disability policy or any other arrangement.
Exception: Any disability which begins more than 30 days after an injury will be considered a sickness for the purpose of determining benefits under the policy.
- "Monthly benefit" means the amount we will pay you when you are disabled.
- "Physician" means a person who is:
 1. operating within the scope of his license; and either
 2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
 3. legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

It will not include you or your spouse, daughter, son, father, mother, sister or brother.

- "Policy Year" means July 1 through June 30.
- "Retirement benefits", when used with the term retirement plan, means money which:
 1. is payable under a retirement plan either in a lump sum or in the form of periodic payments;
 2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and
 3. is payable upon:
 - a. early or normal retirement; or
 - b. disability, if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

NOTE: The following early retirement benefits are not considered retirement benefits under the policy:

- i. those which you receive because the retirement plan compels their receipt; and
 - ii. those which reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan.
- "Retirement plan" means a plan which provides your retirement benefits and which is not funded wholly by your contributions. The term shall

not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

- "Sickness" means illness or disease. It includes pregnancy unless excluded in the General Exclusion section of this certificate of coverage. Disability must begin while you are insured under the policy.
- "Waiting period," as shown in the plan outline, means the continuous length of time you must serve in an eligible class to reach your eligibility date.
- "You" and "your" means you, the employee.

- "Disability" and "disabled" mean that because of injury or sickness:
 1. you cannot perform each of the material duties of your regular occupation; and
 2. after benefits have been paid for 24 months, you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience; or
 3. you, while unable to perform all of the material duties of your regular occupation on a full-time basis, are:
 - a. performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and
 - b. earning currently at least 20% less per month than your indexed pre-disability earnings due to that same sickness or injury.

ENROLLMENT AND DATE INSURANCE STARTS

When can you enroll?

You can enroll if you are:

1. in active employment with your employer; and
2. in a class eligible for insurance.

What is your date of eligibility?

You will be eligible for insurance on the later of these dates:

1. the policy effective date, if you have completed the waiting period; or
2. the day after you complete the waiting period.

What happens during the initial enrollment period?

During the initial enrollment period you can enroll in any one coverage classes shown in the Plan Outline. If you do not choose any coverage option you will automatically be enrolled in Class 1.

When can you change your coverage class?

You may change your coverage class any time following the initial enrollment period by:

1. increasing your coverage by one level; or
2. decreasing your coverage.

In the case of 1. above, you must submit an application and evidence of insurability to us for approval. This will be at your expense.

What happens if your employment terminates and you are later rehired by your employer within the same policy year?

If you are rehired by your employer within the same policy year that your employment terminated, you will be insured for the same coverage that was in effect for you on the date your employment terminated.

When does insurance start?

Insurance will start at 12:01 a.m. on the day determined as follows, but only if your request for insurance is: (1) made with us through your employer; and (2) on a form satisfactory to us.

When you enroll during your initial enrollment period you will be insured for Class 1 coverage on your date of eligibility.

If you choose any other class option you will be insured on the later of these dates:

1. your date of eligibility if you apply before that date; or
2. the date you apply if you do it on or before the 31st day after your date of eligibility.

When you apply for a change in coverage after the initial enrollment period, you will be insured for the selected coverage on the later of these dates:

1. the date you apply; or
2. the date we give our approval if evidence of insurability was submitted.

When will the effective date of insurance be delayed?

The effective date of any initial, increased or additional insurance will be delayed if you are not in active employment because of a disability on the date that insurance would otherwise be effective. The initial, increased or additional insurance will start on the date that you return to active employment.

The monthly benefit will be an amount equal to the lesser of:

1. 60% of your basic monthly earnings; or
2. 60% of your basic monthly earnings less other income benefits shown below;
or
3. the maximum monthly benefit shown in the plan outline.

DISABILITY

When do disability benefits become payable?

We will pay you a monthly benefit after the end of the elimination period when we receive proof that you:

1. are disabled due to sickness or injury; and
2. require the regular attendance of a physician.

What conditions must be met for benefit payments to continue?

We will pay you as long as you remain disabled and require the regular attendance of a physician. But we will not pay any longer than the maximum benefit period shown in the plan outline.

Also, you must give us proof of these facts, at your own expense, when we ask for it.

How is the benefit figured?

Class 1

The monthly benefit will be an amount equal to the lesser of:

1. 60% of your basic monthly earnings; or
2. 60% of your basic monthly earnings less other income benefits shown below;
or
3. the maximum monthly benefit shown in the plan outline.

Class 2

To figure the amount of your monthly benefit:

1. Take the lesser of:
 - a. 70% of your basic monthly earnings; or
 - b. the amount of the maximum monthly benefit shown in the plan outline;
and
2. Deduct other income benefits from this amount.

But, if you are earning more than 20% of your indexed pre-disability earnings in your regular occupation or another occupation, then the monthly benefit will be figured as follows:

1. During the first 12 months, the monthly benefit will not be reduced by any earnings until the gross monthly benefit plus your earnings exceed 100% of your indexed pre-disability earnings. The monthly benefit will then be reduced by that excess amount.
2. After 12 months, the following formula will be used to figure the monthly benefit.

$$(A \text{ divided by } B) \times C$$

A = Your "indexed pre-disability earnings" minus your monthly earnings received while you are disabled.

B = Your "indexed pre-disability earnings".

C = The benefit as figured above.

The benefit payable will never be less than the minimum monthly benefit shown in the plan outline.

Proof of your monthly earnings must be given to us on a quarterly basis. Benefit payments will be adjusted upon receipt of this proof of earnings.

What are "other income benefits"?

Other income benefits means those benefits as follows:

1. The amount for which you are eligible under:
 - a. Workers' or Workmen's Compensation Law;
 - b. occupational disease law; or
 - c. any other act or law of like intent.
2. The amount of any disability income benefits for which you are eligible under any compulsory benefit act or law.
3. The amount of any disability income benefits for which you are eligible under:
 - a. any other group insurance plan;
 - b. any governmental retirement system as a result of your job with your employer.
4. The amount of disability benefits and/or retirement benefits you receive under your employer's retirement plan.

As used here, "receive" does not include any amount rolled over or transferred to any eligible retirement plan as that term is defined in Section 402 of the Internal Revenue Code and any future amendments which affect the definition of an eligible retirement plan.

5. The amount of disability or retirement benefits under the United States Social Security Act, The Canada Pension Plan, or the Quebec Pension Plan, or any similar plan or act, as follows:
 - a. disability benefits for which:
 - i. you are eligible; and
 - ii. your spouse, child or children are eligible because of your disability; or
 - b. retirement benefits received by:

- i. you; and
- ii. your spouse, child or children because of your receipt of the retirement benefits.

These other income benefits, except retirement benefits, must be payable as a result of the same disability for which we pay a benefit.

Item 5.b will not apply to disabilities which begin after age 70 if you are already receiving Social Security retirement benefits while continuing to work beyond age 70.

Benefits under item 5.a above will be estimated if such benefits:

1. have not been awarded; and
2. have not been denied; or
3. have been denied and the denial is being appealed.

The monthly benefit will be reduced by the estimated amount. But, these benefits will not be estimated provided that you:

1. apply for benefits under item 5.a; and
2. request and sign our Agreement Concerning Benefits.

This agreement states that you promise to repay us any overpayment caused by an award received under item 5.a. If benefits have been estimated, the monthly benefit will be adjusted when we receive proof:

1. of the amount awarded; or
2. that benefits have been denied and the denial is not being appealed.

In the case of 2. directly above, a lump sum refund of the estimated amounts will be made.

"Law", "plan", or "act" means the initial enactment and all amendments.

What happens if you receive increases in these other income benefits?

After the first deduction for each of the other income benefits, we will not further reduce your monthly benefit due to any cost of living increases payable under these other income benefits.

What if you receive a lump sum payment?

We will prorate other income benefits which are paid in a lump sum on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over your expected lifetime as determined by us.

When do these benefits cease?

Disability benefits will cease on the earliest of: *

1. the date you are no longer disabled;
2. the date you die;
3. the end of the maximum benefit period.

Must premium payments be made when you are receiving benefits?

No, we will waive premium payments during any period for which benefits are payable.

* Special

RECURRENT DISABILITY

What happens if you try to return to work and become disabled again?

"Recurrent Disability" is a disability which is related to a prior disability for which you received a monthly benefit.

We will treat a recurrent disability as part of the prior disability if, after receiving disability benefits, you:

1. return to your regular occupation on a full-time basis for less than six months; and
2. perform all the material duties of your occupation.

Benefit payments will be subject to the terms of this plan for the prior disability.

If you return to your regular occupation on a full-time basis for six months or more, a recurrent disability will be treated as a new period of disability. You must complete another elimination period.

In order to prevent overinsurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to you under any other group long term disability policy.

SURVIVOR BENEFIT

What happens to your benefit if you die?

We will pay a benefit to your eligible survivor when we receive proof that you died:

1. after disability had continued for 180 or more consecutive days; and
2. while receiving a monthly benefit.

The benefit will be an amount equal to three times your gross monthly benefit.

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

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

"Eligible survivor" means your spouse, if living, otherwise your children under age 25. But, if there are no eligible survivors, payment will be made to your estate.

GENERAL EXCLUSIONS

What disabilities aren't covered?

We will not cover any disability due to:

1. war, declared or undeclared, or any act of war;
2. intentionally self-inflicted injuries;
3. active participation in a riot.

PRE-EXISTING CONDITION EXCLUSION

Are there any other disabilities not covered?

Yes, we will not cover any disability:

1. caused by, contributed to by, or resulting from a pre-existing condition; and
2. which begins in the first 12 months after your effective date.

"Pre-existing condition" means a sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to your effective date.

If you increase your coverage after the initial enrollment period, the following applies to you:

The increase in the amount of coverage will be excluded for any disability:

1. caused by, contributed to by, or resulting from a pre-existing condition; and
2. which begins in the first 12 months after the effective date of the increased coverage.

"Pre-existing condition" means a sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the nine months prior to the effective date of the increased coverage.

MENTAL ILLNESS LIMITATION

Are benefits limited for mental illness?

Benefits for disability due to mental illness will not exceed 24 months of monthly benefit payments unless you meet one of these situations.

1. You are in a hospital or institution at the end of the 24-month period. We will pay the monthly benefit during the confinement.

If you are still disabled when discharged, we will pay the monthly benefit for a recovery period of up to 90 days.

If you become reconfined during the recovery period for at least 14 days in a row, we will pay benefits for the confinement and another recovery period up to 90 more days.

2. You continue to be disabled and become confined:
 - a. after the 24-month period; and
 - b. for at least 14 days in a row.

We will pay the monthly benefit during the confinement.

We will not pay the monthly benefit beyond the maximum benefit period.

"Hospital" or "institution" means facilities licensed to provide care and treatment for the condition causing your disability.

"Mental illness" means mental, nervous or emotional diseases or disorders of any type.

PENSION PLAN CONTRIBUTION

How is your pension plan contribution covered?

While you are receiving disability benefits, we will pay you an extra benefit to cover your contributions to your employer's pension plan. To figure your benefit, take 12 % of basic monthly earnings.

This benefit will not exceed \$1,000 per month.

No reductions for other income benefits will be taken under this extra benefit.

CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIERS

Are you covered if you are not in active employment due to injury or sickness?

We will cover you, subject to premium payments, if you:

1. were insured with the prior carrier at the time of transfer; and
2. are not in active employment due to injury or sickness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Will a disability due to a pre-existing condition be covered?

Benefits may be payable for a disability due to a pre-existing condition if you:

1. were insured by the prior carrier at the time of transfer; and
2. were in active employment and insured under this plan on its effective date.

We will pay you the benefits under this plan if you satisfy the pre-existing condition exclusion under:

1. this plan; or
2. the prior carrier's policy, considering continuous time insured under both policies.

The benefit will be determined according to this plan's benefit schedule, but it will not exceed the prior carrier's benefit percentage, cost of living adjustment benefit and maximum monthly benefit. No benefit will be paid if you cannot satisfy the pre-existing condition exclusion of 1. or 2. directly above.

TERMINATION

When does your insurance terminate?

You will cease to be insured on the earliest of the following dates:

1. the date the policy terminates;
2. the date you are no longer in an eligible class;
3. the date your class is no longer included for insurance;
4. the last day for which you made any required employee contribution;
5. the date employment terminates. Cessation of active employment will be deemed termination of employment, except:
 - a. if you are disabled your insurance will be continued during:
 - i. the elimination period; and
 - ii. while benefits are being paid.
 - b. your employer may continue your insurance by paying the required premium, subject to the following:
 - i. Insurance may be continued for the time shown in the plan outline if you are given a leave of absence.
 - c. The employer must act so as not to discriminate unfairly among employees in similar situations.

SOME GENERAL INFORMATION TO KNOW

When must we be notified of a claim?

You must give us written notice of claim within 30 days of the date disability starts. If that is not possible, you must notify us as soon as you can.

When we receive your written notice of claim, we will send you our claim forms. If you do not receive the forms within 15 days after you sent the notice, you can send written proof of claim without waiting for the form.

When does proof of claim have to be given?

You must give us proof of claim no later than 90 days after the end of the elimination period.

If it is not possible for you to give proof within these time limits, it must be given as soon as reasonably possible.

You must give us proof of continued disability and regular attendance of a physician within 45 days of the date we request the proof.

The proof must cover:

1. the date disability started;
2. the cause of disability; and
3. how serious the disability is.

When are claims paid?

When we receive proof of claim, benefits payable under the policy will be paid monthly during any period for which we are liable.

Who are claims paid to?

All benefits are payable to you or to your estate.

What are our examination rights?

We, at our expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of claim:

1. examined by a physician, other health professional, or vocational expert of our choice; and/or
2. interviewed by an authorized Company representative. This right may be used as often as reasonably required.

How can statements made in any application for this insurance be used?

All statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim unless a copy of your statements has been given to you.

Can legal proceedings be started at any time?

No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

What happens if facts are misstated?

If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and
2. the true facts will decide if and in what amount insurance is valid.

Does this coverage affect workers' or workmen's compensation?

The policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

Can the policyholder act as our agent?

For all purposes of the policy, the policyholder acts on its own or as your agent. Under no circumstances will the policyholder be deemed our agent.

ADDITIONAL SUMMARY PLAN DESCRIPTION
INFORMATION

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions together with your certificate of coverage constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information in this document.

Name of Plan:

ROCHESTER INSTITUTE OF
TECHNOLOGY PLAN

Name and Address of Employer:

ROCHESTER INSTITUTE OF
TECHNOLOGY

One Lomb Memorial Drive
Rochester, NY 14623

Plan Identification Number:

- a. Employer IRS Identification No.: 16-0743140
- b. Plan #: 000503

Type of Welfare Plan:

Disability

Type of Administration:

The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends: June 30

Plan Administrator, Name, Address and Telephone No.:

ROCHESTER INSTITUTE OF
TECHNOLOGY
One Lomb Memorial Drive
Rochester, NY 14623

(716) 475-2428

ROCHESTER INSTITUTE OF is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:

Same as Above

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by First Unum Life Insurance Company, 99 Park Avenue, 6th Floor, New York, New York 10016 (hereinafter referred to as the "insurance company") under policy number 44322. Contributions to the Plan are made as stated under "**Contributions**" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST A POLICY CHANGE

The Employer may request a policy change. Only an officer or registrar of the insurance company can approve a change. The change must be in writing and endorsed on or attached to the policy.

YOUR RIGHTS IN THE EVENT OF PLAN TERMINATION

Termination of the policy under any conditions will not prejudice any payable claim which occurs while this Plan is in force.

THE PLAN MAY TERMINATE

1. If the policyholder fails to pay any premium within the grace period, the policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 31 days following a premium due date during which premium payment may be paid.
2. The policyholder may terminate the policy by advance written notice delivered to the insurance company at least 31 days prior to the termination date. But the policy will not terminate during any period for which premium has been paid.
3. The insurance company may terminate the policy on any premium due date by giving written notice to the policyholder at least 31 days in advance if:
 - a. The number of employees insured is less than 10; or
 - b. Less than 100% of the employees eligible for any noncontributory insurance are insured for it; or
 - c. Less than 75% of the employees eligible for any contributory insurance are insured for it; or
 - d. The policyholder fails:
 - i. To furnish promptly any information which the insurance company may reasonably require; or
 - ii. To perform any other obligations pertaining to the policy.
4. Termination may take effect on any earlier date when both the policyholder and the insurance company agree.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, the insurance company must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do,

you or your authorized representative should contact the insurance company directly.

CLAIMS PROCEDURES

The insurance company will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if the insurance company both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which the insurance company expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the insurance company may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determinations under the Plan will:

1. state the specific reason(s) for determination;
2. reference the specific Plan provision(s) on which the determination is based;
3. describe additional material or information necessary to complete the claim and why such information is necessary;
4. describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from the insurance company on appeal; and
5. disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the insurance company determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). The insurance company will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the insurance company may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U. S. Department of Labor regulations.

The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the insurance company and will be made by a person different from the person who made the initial determination and such person will not be the original decisionmaker's subordinate. In the case of a claim denied on the grounds of a medical judgement, the insurance company will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claims, the insurance company will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

1. the specific reason(s) for determination;
2. a reference to the specific Plan provision(s) on which the determination is based;
3. a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
4. a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
5. the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
6. the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation, 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".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, 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.

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.

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 the 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 a 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 that 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 claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER RIGHTS

The insurance company, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. The insurance company and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to the insurance company and its affiliate UnumProvident Corporation discretionary authority to make benefit determinations under the Plan. The insurance company and UnumProvident Corporation may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.