UNUMPROVIDENT

Port Huron Hospital

Your Group Long Term Disability Plan

Identification No. 00292821.001

Underwritten by Unum Life Insurance Company of America

05-2006

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CERTIFICATE OF COVERAGE

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UNUM Life Insurance Company of America (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

PLAN OUTLINE

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Description of Eligible Classes

All Employees

Amount of Insurance

Option 1

- 50% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit.

- The maximum monthly benefit is $5,000.

Option 2

- 40% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit.

- The maximum monthly benefit is $5,000.

Option 3

- 25% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit.

- The maximum monthly benefit is $5,000.

Maximum Benefit Period

Age at Disability	Maximum Benefit Period
Less than 60	To Age 65 but not less than 5 years
60-64	5 Years
65-69	To Age 70 but not less than 1 year
70 and Over	1 Year

Elimination Period:

- 90 days

Minimum Requirement for Active Employment: 24 hours per week

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Definition of Basic Monthly Earnings

"Basic monthly earnings" means your monthly rate of earnings from the employer in effect on:

1. the last day of the last payroll period which ends in October, just prior to the date the disability begins; or
2. the date of hire, if he was not insured on the October 31, plan anniversary date.

It does not include commissions, bonuses, overtime pay or other extra compensation.

Waiting Period:

- If you were in an eligible class on or before the plan effective date: None
- If you entered an eligible class after the plan effective date: First day of the month following 90 days of active employment

You must be in continuous active employment in an eligible class during the specified waiting period.

Contributions

- 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	Time Limit
Temporary Layoff	To the end of the insurance month following the insurance month in which the layoff begins.

Re-enrollment

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"Re-enrollment period" means a period designated by the Employer and the Company, during which time an employee may make written application for coverage under this plan. Port Huron Hospital will have a re-enrollment period beginning the week in which November 1st occurs and continuing for the next four consecutive weeks. Marwood Nursing & Rehab will have a re-enrollment period beginning April 1st and ending April 30th.

The following applies to employees who are eligible for insurance coverage as shown in the plan specifications.

1. During each re-enrollment period, the employee may choose one of the following:

   a. enroll in the plan;

   b. increase in coverage;

   c. decrease in coverage;

   d. keep coverage at the same level; or

   e. choose not to participate in the plan.

2. Evidence of insurability will not be required for:

   a. those newly eligible employees enrolling during the re-enrollment period; or

   b. those employees who were previously eligible to enroll during prior enrollment periods and chose not to enroll in the plan; or

   c. those employees who increase their coverage.

The effective date of insurance for these employees will be on the first day of the pay period following:
a. January 1st for Port Huron Hospital; and
b. May 1st for Marwood Nursing & Rehab

Employees who choose not to participate in the plan will not be covered.

The following applies to employees who increase their coverage during the re-enrollment period. This plan will not cover the increase in the amount of coverage for any disability:

1. caused by, contributed to by, or resulting from a pre-existing condition; and

2. which begins in the first 24 months after the effective date of the increased coverage.

A "pre-existing condition" means a sickness or injury for which the insured received medical treatment, consultation, care or drugs or medicines in the 12 months prior to the effective date of the increased coverage.

The following applies to an employee who is currently enrolled in the plan and fails to reenroll in the plan:

He will continue to be insured for the same coverage option for which contributions have been deducted.

The following applies to any employee who was previously declined for this coverage by the Company:

The employee must submit an application and evidence of insurability to the

Company for approval. This will be at the employee's expense.

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An employee will be insured on the first day of the pay period which follows the date the Company gives its approval, for which contributions have been deducted.

Discretionary Authority

In making any benefits determination under the summary of benefits, we shall have the discretionary authority both to determine your eligibility for benefits and to construe the terms of the summary of benefits.

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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 regular 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.

- "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 a proprietorship, partnership or corporation which becomes a participating employer by completing an application for participation and having the application approved by the Company and the trustees of the fund. This includes any division, subsidiary or affiliated company named in the summary of benefits.

- "Enrollment period" means one of the following periods during which you may first make written application for coverage under this plan:

  1. if you are eligible for insurance on the plan effective date, a period before the plan effective date set by your employer and us.

  2. if you become eligible for insurance after the plan effective date, the period which ends 61 days after your eligibility date.

- "Evidence of insurability" means a statement or proof of your medical history upon which we will determine your acceptance for insurance.

- "Home office" means the UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

- "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.

- "Injury" means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur and disability must begin while you are insured under the policy.

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- "Monthly benefit" means the amount we will pay you when you are disabled.

- "Partial disability" and "partially disabled" - see the end of these terms.

- "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.

- "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.

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- "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.

For employees employed as airplane pilots, co-pilots or crew members

- "Disability" and "disabled" mean that because of injury or sickness you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute disability.

- "Partial disability" and "partially disabled" mean that because of injury or sickness you, while unable to perform all the material duties of your regular occupation on a full-time basis, are:

  1. performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and

  2. currently earning at least 20% less per month than your indexed pre-disability earnings due to that same injury or sickness.

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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.

When does insurance start?
Insurance will start at 12:01 a.m. on the day determined as follows, but only if your written application for insurance is:

1. made with us through your employer; and
2. on a form satisfactory to us.

You will be insured on the first day of the pay period:

1. for which contributions have been deducted; and
2. which follows the latest of:
   a. the date you made written application for insurance before the 61st day after your eligibility date; or
   b. the date the Company gives its approval, if you:
      i. make written application for insurance more than 61 days after your eligibility date; or
      ii. terminated your insurance while continuing to be eligible.

In the case of ii. above, the employee must submit an application and evidence of insurability to the Company for approval. This will be at your expense.

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.

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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.

When do disability benefits for partial disability become payable?
When we receive proof that you are partially disabled within 31 days of the end of a period during which you received disability benefits, we will pay a monthly benefit. The partial disability must result from the injury or sickness that caused disability.

How is the benefit figured?

Option 1

To figure the amount of your monthly benefit:

1. Take the lesser of:

   a. 50% of your basic monthly earnings; or
   b. the amount of the maximum benefit shown in the plan outline.

Option 2

To figure the amount of your monthly benefit:

1. Take the lesser of:

   a. 40% of your basic monthly earnings; or
   b. the amount of the maximum benefit shown in the plan outline.

Option 3

To figure the amount of your monthly benefit:

1. Take the lesser of:

   a. 25% of your basic monthly earnings; or
   b. the amount of the maximum benefit shown in the plan outline.

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 monthly benefit will be reduced by 50% of your monthly earnings received while you are disabled.

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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.

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;
4. the date your current earnings exceed 80% of your indexed pre-disability earnings.

Must premium payments be made when you are receiving benefits?
No, we will waive premium payments during any period for which benefits are payable.

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.

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"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 24 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 12 months prior to your effective date.

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.

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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 your employer's coverage under the policy terminates;
3. the date you are no longer in an eligible class;
4. the date your class is no longer included for insurance;
5. the later of:
   a. the date employment terminates; or
   b. the last day for which your employee contribution has been made.

   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 temporarily laid off.
      ii. The employer must act so as not to discriminate unfairly among employees in similar situations.

VOLUNTARY LONG TERM DISABILITY PORTABILITY PRIVILEGE

What are the terms of the portability privilege?

When your coverage would otherwise terminate under this plan because you end employment with the employer, you may elect to continue your disability income coverage for 12 months and without medical evidence of insurability. But you must have been insured for at least twelve consecutive months just before the date your employment terminated.

Coverage may not be continued for any of the following reasons if:

1. you are disabled under the terms of the plan, or upon recovery of such disability;
2. you failed to pay any required premium;
3. you retire;
4. you are on an approved leave of absence;
5. you become covered under any other group long term disability income plan;
6. the group policy terminates; or
7. the employer's coverage under the group policy terminates.

To keep your insurance in force you must:

1. make written application to the Company within 31 days after the date your insurance would otherwise terminate; and

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2. pay the required premium to the Company. The first premium payment must be made no later than 31 days after the date your insurance would otherwise terminate.

Insurance will cease on the earliest of these dates:

1. the date you failed to pay any required premium;
2. the date you retire;
3. the date the group policy is terminated; or
4. the date you become insured under any other group long term disability income plan; or
5. the date following 12 months of coverage.

"Group policy" means the policy issued to the trustees of the multiple employer trust in which your employer participates.

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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. But you may not give proof later than one year after the time it is otherwise required.

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. But if a benefit is payable to your estate, or if you are a minor, or you are not competent, we have the right to pay up to $1,000 to any of your relatives whom we consider entitled. If we pay benefits in good faith to a relative, we will not have to pay such benefits again.

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?
In the absence of fraud, 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:

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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.

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Additional Summary Plan Description Information

Name of Plan:
PORT HURON HOSPITAL

Name and Address of Employer:
PORT HURON HOSPITAL

1221 Pine Grove Avenue
P. O. Box 5011
Port Huron, MI 48061-5011

Plan Identification Number:
a. Employer IRS Identification No.: 38-1369611
b. Plan #: 000510

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 Summary of Benefits issued to the Plan.

ERISA Plan Year Ends: December 31

Plan Administrator, Name, Address and Telephone No.:
PORT HURON HOSPITAL
1221 Pine Grove Avenue
P. O. Box 5011
Port Huron, MI 48061-5011

(810) 989-3106

PORT HURON HOSPITAL 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, and any Trustee of the Plan.

Funding and Contributions:
The Plan is funded as an insured plan under identification number 292821 issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122. 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.

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EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer may request a Summary of Benefits 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 Summary of Benefits.

YOUR RIGHTS IN THE EVENT OF PLAN TERMINATION

Termination of the Summary of Benefits under any conditions will not prejudice any payable claim which occurs while this plan is in force.

THE PLAN MAY TERMINATE

1. If the Employer fails to pay any premium within the grace period, the Summary of Benefits will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 45 days following a premium due date during which premium payment may be paid.

2. The Employer may terminate the Summary of Benefits by advance written notice delivered to the insurance company at least 31 days prior to the termination date. But the Summary of Benefits will not terminate during any period for which premium has been paid.

3. The insurance company may terminate the Summary of Benefits on any premium due date by giving written notice to the Employer 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 Employer fails:

      i. To furnish promptly any information which the insurance company may reasonably require; or

      ii. To perform any other obligations pertaining to the Summary of Benefits.

4. Termination may take effect on any earlier date when both the Employer and the insurance company agree.

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:

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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 sue in federal court; 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;

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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 civil suit under federal law;

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 circustances, 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 Pension and Welfare Benefit 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 desciption. 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

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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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 responsiblities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

DISCRETIONARY ACTS

In exercising its discreationary powers under the Plan, the Plan Administrator, and any designee (which shall include the insurance company as a claims fiduciary) will have the broadest discretion permissible under ERISA and any other applicable laws, and its decisions will constitute final review of your claim by the Plan. Benefits under this Plan will be paid only if the Plan Administrator, or its designee (including the insurance company), decides in its discretion that the applicant is entitled to them.