



**Basic and Optional Long Term Disability
Group Insurance**

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CERTIFICATE OF COVERAGE

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.

Shun RWays

President

PLAN OUTLINE

Description of Eligible Classes

- Class 1 Eligible employees earning less than \$20,000 per year and eligible employees earning in excess of \$20,000 per year who do not elect Class 2 coverage
- Class 2 Eligible employees earning in excess of \$20,000 per year who elect additional protection for annual earnings in excess of \$20,000 per year
- Class 3 All Employees of University of Arkansas at Batesville

Amount of Insurance

Class 1

- 60% (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 \$1,000.

Class 2 and 3

- 60% (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 \$5,000.

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 or the end of the accumulated sick leave, whichever is later.

Minimum Requirement for Active Employment: 20 hours per week

Definition of Basic Monthly Earnings

For Physicians:

"Basic monthly earnings" means base pay only. It includes shift differential but does not include commissions, bonuses, overtime pay and any other extra compensation.

For all other employees:

"Basic monthly earnings" means your monthly rate of earnings from your employer in effect just prior to the date disability begins. It includes shift differential but does not include commissions, bonuses, overtime pay and any other extra compensation.

Waiting Period:

- If you were in an eligible class on or before the policy effective date: None
- If you entered an eligible class after the policy effective date: None

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

Contributions

Class 1 and 2

- The cost of your insurance is paid entirely by your employer for the first \$20,000 per year of covered earnings. For earnings in excess of \$20,000 annually the cost of your insurance is paid entirely by the employee.

Class 3

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

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
Leave of Absence for Educational Purposes	Up to twelve months.
Temporary Layoff or Leave of Absence other than Family and Medical Leave of Absence	Up to twelve months.
Family and Medical Leave of Absence	UNUM will continue your insurance in accordance with your employer's Human Resource policy on family

and medical leaves of absence - as if you were in active employment, if the following conditions are met:

1. premiums are paid, and
2. your employer has approved your leave in writing.

Coverage will be continued for up to the greater of:

1. the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments, or
2. the leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, upon your return to active employment:

1. no new waiting periods will be applied,
 2. no new pre-existing conditions exclusions will be applied, and
 3. no evidence of insurability will be required,
- to reinstate the coverage in effect on the date before the leave began.

The time period in the Pre-Existing Condition Exclusion will continue to run through your family or medical leave of absence.

Discretionary Authority

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

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.
- "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 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.
- "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.

- "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.
- "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.

Note: "Employer's retirement plan" is deemed to include any retirement plan:

1. which is part of any federal, state, county, municipal or association retirement system; and
 2. for which you are eligible as a result of employment with the employer.
- "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.

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.

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 you enroll for insurance with us through your employer on a form satisfactory to us.

If you do not contribute toward the plan's cost, your insurance will start on your eligibility date.

But no initial, increased or additional insurance will apply to you if you are not in active employment on the effective date of such insurance because of a disability. Such insurance will start for you on the day you return to active employment.

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

To figure the amount of your monthly benefit:

1. Take the lesser of:
 - a. 60% 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.

Class 2

To figure the amount of your monthly benefit:

1. Take the lesser of:
 - a. 60% 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 benefits from your employer's retirement plan you:
 - a. receive as disability benefits;
 - b. voluntarily elect to receive as retirement benefits; or
 - c. are eligible to receive as retirement benefits when you reach the greater of age 62 or normal retirement age, as defined in 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;
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.

ONE YEAR SURVIVOR INCOME BENEFIT*

What happens to your benefit if you die after 12 months of disability?
We will pay a benefit to your eligible survivor when we receive proof that you died:

1. after you had been disabled for six or more consecutive months; and
2. while receiving a monthly benefit.

We will pay this benefit monthly for one year from the date of death. The amount will be equal to 66 2/3% of your last 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, or if your spouse dies before the final monthly benefit is paid, then, your children who are under age 25.

"Last monthly benefit" means the monthly benefit we paid to you immediately prior to your death but not including any adjustment for earnings.

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;

*Special

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.

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.

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:
 - a) temporarily laid off; or
 - b) given leave of absence.
 - ii. The employer must act so as not to discriminate unfairly among employees in similar situations.

CONVERSION PRIVILEGE

Under what conditions can you convert?

When your insurance under this plan terminates because you end employment with the policyholder, you may obtain converted disability income coverage without medical evidence of insurability. But you must have been insured for at least twelve consecutive months just before your insurance under this plan terminated. These twelve months will be considered to include the time you were insured for group long term disability under both this plan and the one it replaced, if any.

Who may not convert?

The conversion privilege is not available to you if:

1. your insurance under this plan terminates for any of the following reasons:
 - a. this plan terminates;
 - b. this plan is amended to exclude from coverage the class of employees to which you belong;
 - c. you no longer belong to a class of employees eligible for coverage under this plan;
 - d. you retire (when you receive payment from any employer's retirement plan as recognition of past services or have concluded your working career);
 - e. you failed to pay any required premium;
2. you are or become insured for long term disability insurance under another group plan within 31 days after termination;
3. you are disabled under the terms of this plan;
4. you recover from a disability and do not return to work for the policyholder; or
5. you are on a leave of absence.

When must you apply for the conversion coverage?

You must apply for and pay the first quarterly premium for the conversion coverage within 31 days after your insurance terminates under this plan.

Is the conversion coverage the same as that provided under this plan?

The Company governs the form of coverage, the benefits and the amounts. The benefits and amounts may differ from those under this plan.

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 30 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:

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.

NOTICE

This is to advise you of the addresses and telephone numbers of the Insurance Department and the office where the policy is serviced.

Service

Office: Unum
5350 Poplar Ave.
Suite 150
Memphis, Tennessee 38119
Telephone: (901) 683-8680

Insurance

Department: Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Telephone: (501) 371-2600
Consumer: 1-800-852-5494
Public Employee Claims: (501) 371-2700

ADDITIONAL CLAIM AND APPEAL INFORMATION

APPLICABILITY OF ERISA

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. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information contained in this document.

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, Unum Life Insurance Company of America (hereinafter referred to as 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.

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 Unum Group discretionary authority to make benefit determinations under the Plan. The insurance company and Unum Group 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.