YOUR BENEFIT PLAN

CENTRAL MAINE HEALTHCARE CORP.

Long Term Disability

Questions about Your Coverage

In the event You have questions regarding any aspect of Your coverage, You should contact Your Employee Benefits Manager or You may write to us at:
The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call Us at: 1-800-523-2233
When calling, please give Us the following information:
1) the policy number; and
2) the name of the policyholder (employer or organization), as shown in Your Certificate of Insurance.

Or You may contact Our Sales Office:
Hartford Life Insurance Company
Group Sales Department
150 Federal Street, Suite 1025
Boston, MA 02110
TOLL FREE: 800-871-2071
FAX: 617-378-4633

If you have a complaint, and contacts between you and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require we provide you with additional contact information:

For Residents of:	Write	Telephone
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904	1(800) 852-5494
California	State of California Insurance Department Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013	1(800) 927-HELP
Illinois	Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767	Consumer Assistance: 1(866) 445-5364 Officer of Consumer Health Insurance: 1(877) 527-9431
Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1(800) 622-4461 1(317) 232-2395 (in the Indianapolis Area)
Virginia	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23209	1(800) 552-7945 (inside Virginia) 1(804) 371-9741 (outside Virginia)
Wisconsin	Office of the Commissioner of Insurance Complaints Department P.O. Box 7873 Madison, WI 53707-7873	1(800) 236-8517 (outside of Madison) 1(608) 266-0103 (in Madison) to request a complaint form.

The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read This certificate carefully.

Florida The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida.

Maryland The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all the benefits required by Maryland law.

Montana The benefits of the policy providing your coverage are governed primarily by the law of a state other than Montana.

Georgia

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

North Carolina

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.

THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

Texas

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

You may also write to The Hartford at:
P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una quaja al:

1-800-523-2233

Usted tambien puede escribir a The Hartford:
P.O. Box 2999
Hartford, CT 06104-2999

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

You may write the Texas Department of Insurance at:
P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CERTIFICATE OF INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

Policyholder: TRUSTEE OF THE GROUP VOLUNTARY LIFE AND DISABILITY INSURANCE TRUST
Policy Number: GLT-676252 Participating Employer: Central Maine Healthcare Corp.
Policy Effective Date: January 1, 2007 Account Number: 676252
Policy Anniversary Date: January 1, 2008

We have issued The Policy to the Policyholder. Our name, the Policyholder's name, the Participating Employer's name, The Policy Number and the Participating Employer's Account Number are shown above. The provisions of the Participating Employer's coverage under The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Richard G. Costello, *Secretary* **Thomas M. Marra, *President***

A note on capitalization in this certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

TABLE OF CONTENTS

SCHEDULE OF INSURANCE

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy.

Cost of Coverage:
You must contribute toward the cost of coverage.

Eligible Class(es) for Coverage: All Full-time and Regular Part-time Active Physicians who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal Employees.

Full-time Employment:	at least 20 hours weekly, excluding on-call hours
Part-time Employment:	at least 20 hours weekly, excluding on-call hours

Eligibility Waiting Period for Coverage:
1) None - if You are working for the Employer on the Participating Employer Effective Date; or
2) The first day of the month coinciding with or next following 1 month(s) of employment - if You start working for the Employer after the Participating Employer Effective Date.

The time period(s) referenced above are continuous.

Elimination Period: 90 day(s)

Maximum Monthly Benefit: the least of:
1) $10,000;
2) the Benefit Percentage applicable to You multiplied by the amount of Your Pre-disability Earnings on which premium for You has been paid; or
3) the Benefit Percentage applicable to You multiplied by the amount of Your Pre-disability Earnings.

Minimum Monthly Benefit: the greater of:
1) $100; or
2) 10% of the Maximum Monthly Benefit for which You are eligible under the terms of The Policy, before the deduction of Other Income Benefits.

Benefit Percentage:
Option 1: 50%
Option 2: 60%

Maximum Duration of Benefits

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 62	To Age 65, or for 48 months, if greater
Age 62	48 months
Age 63	42 months
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 and over	18 months

Additional Benefit

Family Care Credit Benefit
see Benefit

Survivor Income Benefit
see Benefit

Workplace Modification Benefit
see Benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:
1) the Participating Employer Effective Date; or
2) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Enrollment: *How do I enroll for coverage?*
To enroll for coverage you must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to Your Employer.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You must give Us Evidence of Insurability satisfactory to Us.

Evidence of Insurability: *What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to the Company?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physician's statement; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Your expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Monthly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Your coverage will start on the earliest of:
1) the date You become eligible, if You enroll or have enrolled by then; or
2) the date on which You enroll, if You do so within 31 days after the date You are eligible; or
3) the date We approve Your Evidence of Insurability, for benefit amounts requiring Evidence of Insurability.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Can I change my benefit options?*
You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre existing Conditions Limitations.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?
Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

1) Deferred Effective Date; and
2) Pre existing Conditions Limitations.

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*
If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the Participating Employer Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?
If You become insured under The Policy on the Participating Employer Effective Date and were covered under the Prior Policy on the day before the Participating Employer Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

1) the Participating Employer Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the Monthly Benefit which was paid by the Prior Policy; or
2) the Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Participating Employer Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received Monthly benefits for disability under the Prior Policy, and You returned to work as a Active Employee before The Participating Employer Effective Date, then, if within 6 months of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date The Policy no longer insures Your class;
3) the date the premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the date Your Employer terminates Your employment;
6) the date You cease to be a Full-time or Part-time Active Employee in an eligible class for any reason; or
7) the date Your Employer ceases to be a Participating Employer;unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in The Policy;
2) is subject to payment of premium by the Employer; and
3) terminates if:
    a) The Policy terminates;
    b) Your Employer ceases to be a Participating Employer; or
    c) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*
No premium will be due for You:

1) after the Elimination Period; and
2) for as long as benefits are payable.

Extension of Benefits for Total Disability: *Do my benefits continue if the Policy terminates?*
If You are entitled to benefits while Disabled and The Participating Employer's coverage terminates, benefits:

1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Participating Employer's coverage for any reason will have no effect on Our liability under this provision.

Conversion Right: *If my coverage under The Policy ends, do I have a right to conversion?*
If Your insurance terminates because:

1) Your employment ends for a reason other than Your retirement; or
2) You are no longer in an eligible class;

and if:

1) You have been continuously insured for at least 12 consecutive month(s) under The Policy or under both The Policy and the Prior Policy;
2) a Disability is not preventing You from performing duties of Your Occupation;
3) The Policy has not terminated; and
4) You are not eligible or covered for similar benefits under another group Policy;

then You are eligible to enroll for personal insurance under another group policy called the group long term disability conversion policy.

How do I convert my Coverage?
To obtain coverage under the group long term disability conversion Policy, You must:
1) send Us a written enrollment request; and
2) pay the required premium and enrollment fee for the conversion Policy;

within 31 days of the termination of Your insurance.

If You meet the preceding conditions, We will issue You a certificate of insurance under the group long term disability conversion Policy. Such coverage will:
1) be issued without Evidence of Insurability;
2) be on one of the forms then being issued by Us for conversion purposes; and
3) be effective on the day following the date Your insurance under The Policy terminates.

The coverage available under the conversion Policy may differ from The Policy. We will determine the terms of the group long term disability conversion Policy, including:
1) the type and amount of coverage provided; and
2) the premium payable;

based on the kinds of insurance provided by the group long term disability conversion Policy at the time such enrollment request is made.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Policy?*
We will pay You a Monthly Benefit if You:
1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness Benefits: *Are benefits limited for Mental Illness?*
If You are Disabled because of:
1) Mental Illness that results from any cause;
2) any condition that may result from Mental Illness;

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:
1) for as long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) if not confined, or after you are discharged and still Disabled, for a total of 24 month(s) for all such disabilities during your lifetime.

Substance Abuse Limitation: *Are benefits limited for alcoholism or Substance Abuse?*
If You are Disabled because of:
1) alcoholism; or
2) the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance;

then, subject to all other Policy provisions, benefits will be payable for 24 month(s), provided You are:
1) confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) actively participating in a rehabilitative program approved by Us.

Recurrent Disability: *What happens if I Recover but become Disabled again?*

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You are no longer Disabled and then become Disabled again and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 180 day(s) of the prior Period of Disability;

the prior Period of Disability and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You are no longer Disabled and remain so for 180 day(s) or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits, and is subject to all of the other terms and conditions of The Policy in effect at that time.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit: *How are my Disability benefits calculated?*
If You remain Disabled after the Elimination Period and are earning 20% or less of Your Pre-disability Earnings, We will determine Your Monthly Benefit as follows:

1) multiply Your Pre-disability Earnings by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*
If You remain Disabled after the Elimination Period, and are earning more than 20% of Your Pre-disability Earnings, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

1) multiply Your Pre-Disability Earnings by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1) the day You first start work and are earning more than 20% of Your Pre-disability Earnings; or
2) the end of the Elimination Period.

If You remain Disabled, are not receiving benefits under the Return to Work Incentive described above, and are earning more than 20% of Your Pre-disability Earnings, We will calculate Your Monthly Benefit as the greater of:

1) the Proportionate Loss Formula; or
2) the 50% Offset Formula.

Proportionate Loss Formula: (**A** divided by **B**) x **C** = **D**, where:

A = Your Indexed Pre-disability Earnings minus Your Current Monthly Earnings;
B = Your Indexed Pre-disability Earnings;
C = the Monthly Benefit which would be payable if You were Disabled and not earning more than 20% of Your Indexed Pre-disability Earnings; and
D = the Monthly Benefit payable

50% Offset Formula: (**W** – **X**) – **Y** = **Z**, where:

W = the Maximum Monthly Benefit;
X = 50% of Your Current Monthly Earnings;
Y = all Other Income Benefits; and
Z = the Monthly Benefit payable

What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-disability Earnings?
If the sum of Your Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*
Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*
If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:
1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified professional;
5) the date of Your death;
6) the last day benefits are payable according to the Maximum Duration of Benefits Table; or
7) the date Your Current Monthly Earnings exceed 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
8) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?*
If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:
1) Family Care means the care or supervision of:
   a) Your children under age 13; or
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) the maximum monthly deduction allowed for each qualifying child or family member is:
   a) $350 during the first 12 months of Rehabilitation; and
   b) $175 thereafter;
   but in no event may the deduction exceed the amount of Your monthly earnings;
3) Family Care Credits may not exceed a total of $2,500 during a calendar year;
4) the deduction will be reduced proportionally for periods of less than a month;
5) the charges for Family Care must be documented by a receipt from the caregiver;
6) the credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitation program; or
   b) Family Care Credits for 24 months have been deducted during Your Disability; and
7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Benefit. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Pre-disability Earnings.

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability Benefits?*
If You were receiving a Monthly Disability Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:
1) of Your death; and
2) that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

We will pay the Survivor Income Benefit:
1) to Your Surviving Spouse;
2) if no Surviving Spouse, in equal shares to Your Surviving Children; or
3) if no Surviving Spouse or Surviving Children, to Your estate.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

The Survivor Income Benefit is calculated as 3 times your Maximum Monthly Benefit.

Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner, provided You have executed a domestic partner affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are:
1) under age 21; or
2) between the ages of age 21 and 25, inclusive, and in full-time attendance at an institution of learning.

The term Surviving Children will also include any other children related to You by blood or marriage or domestic partnership and who:
1) lived with You in a regular parent-child relationship; and
2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*
We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:
1) Your Disability is covered by The Policy;
2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such workplace modification shall not exceed the amount equal to item number 1 of the amount of the Maximum Monthly Benefit.

We have the right, at Our expense, to have You examined or evaluated by:
1) a Physician or other health care professional; or
2) a vocational expert or rehabilitation specialist;
of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:
1) the proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Employee.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and We will not pay a benefit for any Disability:
1) unless You are under the Regular Care of a Physician;

2) that is caused or contributed to by war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:
1) was sponsored by Your Employer; and
2) was terminated before the Effective Date of The Policy;
no benefits will be payable for the Disability under The Policy.

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:
1) You have not received Medical Care for the condition for 3 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 12 consecutive month(s).

Pre-existing Conditions means:
1) any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2) any manifestations, symptoms, findings, or aggravations relating to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;
for which You received Medical Care during the 3 month(s) period that ends the day before:
1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a physician or other health care provider:
1) is consulted or gives medical advice; or
2) recommends, prescribes or provides Treatment.

Treatment includes, but is not limited to:
1) medical examinations, tests, attendance, or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*
You must give Us, written, electronic or telephonic notice of a claim within 30 days after Disability or loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include Your name, Your address and the Participating Employer Account Number.

Claim Forms: *Are special forms required to file a claim?*
We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written, electronic or telephonic proof which fully describes the nature and extent of Your claim.

Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:
1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;

3) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
    a) medical, employment and financial information; and
    b) any other information We may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*
To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss: *When must proof of Loss be given?*
Written Proof of Loss must be sent to Us within 90 days after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within 30 day(s) of the request.

Claim Payment: *When are benefit payments issued?*
When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

Arbitration: *What recourse do I have if I disagree with the Company about the decision which was made regarding my claim for Disability Benefits?*
If You disagree with Us about a decision We make, after Our final review of Your claim for Disability Benefits, You have the right to refer the dispute to an arbitrator.

To proceed You must call the main office of the American Arbitration Association in Washington, D.C. to request arbitration proceeding. You shall invoke the arbitration proceeding in accordance with the procedures established for Employee Benefit Plan Claims by the American Arbitration Association.

Arbitration shall be conducted by a sole, neutral arbitrator selected from the approved panel maintained by the American Arbitration Association for employee benefit disputes.

The expense of the arbitration shall be borne equally by You and Us unless otherwise ordered by the arbitrator.

The decision of the arbitrator shall be final and binding, and judgment upon the award may be entered in any court having jurisdiction thereof.

Social Security: *When must I apply for Social Security Benefits?*
You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*
We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When We determine that You or Your Dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.
Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You or Your Dependent are later awarded Social Security disability benefits, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security Benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*
We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

Subrogation: *What are the Company's subrogation rights?*
If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

Reimbursement: *What are the Company's Reimbursement Rights?*
We have the right to request to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

1) a legal judgment;
2) an arbitration award; or
3) a settlement or otherwise;

You must reimburse Us for the lesser of:

1) the amount of payment made or required to be made by Us; or
2) the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

Third Party means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:

1) sooner than 60 days after the date proof of loss is given; or
2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

Misstatements: *What happens if facts are misstated?*
If material facts about You were not stated accurately:

1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1) in the usual way; and
2) for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Bonuses means the monthly average of monetary bonuses You received from:

1) the Employer during the 12 month(s) period immediately prior to the last day You were Actively at Work before You became Disabled;
2) the Employer during the total period of time You worked for the Employer, if less than the above period; or
3) any employer or for any work You perform during Your Period of Disability.

Commissions means the monthly average of monetary commissions You received from:

1) the Employer during the 12 month(s) period immediately prior to the last day You were Actively at Work before You became Disabled;
2) the Employer during the total period of time You worked for the Employer, if less than the above period; or
3) any employer or for any work You perform during Your Period of Disability.

Current Monthly Earnings means monthly earnings You receive from:

1) Your Employer;
2) other employment; and
3) any other work for pay or profit;

while You are Disabled and eligible for the Disabled and Working Benefit. Current Monthly Earnings will include Bonuses and Commissions and will be pro-rated as necessary.

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:

1) Your Occupation during the Elimination Period; and
2) Your Occupation following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are 80% or more of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

Your Disability must result from:
1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to maintain a license to perform the duties of an occupation, alone, does not mean that You are Disabled. You will not be considered Disabled solely because Your professional or occupational license or certification is suspended, revoked, restricted or surrendered.

Employer means the Policyholder.

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled work week is an Essential Duty.

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by 5%. The first adjustment will take effect on the first day of the month following receipt of 12 months of benefits, if You are working and earning greater than 20% of Your Pre-disability Earnings. After this first adjustment, Your Pre-disability Earnings will be increased annually by an additional adjustment of 5%, compounded on the first day of the month following each anniversary of the date of the initial adjustment, as long as You continue to receive benefits while working and are earning greater than 20% of Your Pre-Disability Earnings.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You, or Your family or to a third party on Your behalf, pursuant to any:
1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with the Employer;
3) income from Your Employer under any plan or arrangement of coverage, including income from any accumulated sick time, salary continuation or paid time off plan, whether insured or not, during the first 12 months of Your Disability, only to the extent that the sum of Your income from Your Employer, Monthly Benefit, Current Monthly Earnings and any Other Income Benefits exceed 100% of Your Pre-Disability Earnings;
4) income from Your Employer under any plan or arrangement of coverage, including income from any accumulated sick time, salary continuation or paid time off plan, whether insured or not, after the first 12 months of Your Disability;

5) mandatory "no fault" automobile insurance plan;
6) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
7) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under Your Employer's Retirement plan;
2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
   d) similar plan or act;

   that You, Your spouse and children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

Other Income Benefits will not include:

1) early retirement benefits under the United States Social Security Act that are not received;
2) the amount of any increase in benefits paid under any federal or state law, if the increase:
   a) takes effect after the date benefits become payable under The Policy; and
   b) is a general increase which is required by law and applies to all persons who are entitled to such benefits;
3) group credit or mortgage disability insurance benefits;
4) any benefits or proceeds from:
   a) personal investment income;
   b) Veteran's Administration Disability and military retirement benefits You are receiving prior to becoming Disabled;
   c) a military retirement pension plan;
   d) defined contribution plan from a professional corporation;
   e) individual or Employer sponsored IRA or tax sheltered annuity, or deferred compensation plan;
   f) employee stock option plan or any thrift plan;
   g) a partner or proprietor H.R. 10 (Keogh) plan under the self-employed individual Retirement Act;
   h) a capital account; or
   i) individual insurance benefits.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 60 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.

Participating Employer means an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Policy.

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Pre-disability Earnings means, for sole proprietor, partners, members of a limited liability company taxable as a partnership under the federal income tax laws, or share holders in a S-Corporation:

1) the monthly average of earnings from Your Employer reported as 'net earnings from self-employment' for federal income tax purposes for:
   a) the 1 tax year(s) immediately prior to the last day You were Actively at Work before You became Disabled; or
   b) the number of months You were employed in this capacity, if less than the above period; but not
2) contributions You make through a salary reduction agreement with Your Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan, for the same period as above.

Pre-disability Earnings does not include dividends, capital gains and returns of capital.

Pre-Disability Earnings means, for hourly paid Employees, the product of:

1) the average number of hours You worked per month, not including overtime or on-call hours unless regularly scheduled, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
2) Your hourly wage immediately prior to the last day You were Actively at Work before You became Disabled.

Pre-Disability Earnings means, for all other Employees, Your regular monthly rate of pay, not counting bonuses, commissions and tips and tokens, or any other fringe benefits or extra compensation, in effect on the last day You were Actively at Work before You became Disabled. Overtime pay or on-call pay is also not included, unless regularly scheduled.

Prior Policy means the long term disability insurance carried by the Policyholder on the day before the Participating Employer Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;
   to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or someone in a similar relationship in law to You.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

Trust means the Policyholder stated on the face page of The Policy.

We, Our, or Us means the insurance company named on the face page of The Policy.

Your Occupation means Your Occupation, as it is recognized in the general workplace, that You were routinely performing prior to becoming Disabled. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

If You are a Physician, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.

You or Your means the person to whom this certificate is issued.

AMENDATORY RIDER

This rider is attached to all certificates given in connection with The Policy and is effective on The Policy Effective Date.

This rider is intended to amend Your certificate, as indicated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your certificate will affect Your coverage.

For California residents:

1) The following is added to the definition of **Surviving Spouse** in the **Survivor Income Benefit:**
   "Spouse" will also include an individual who is in a registered domestic partnership with You in accordance with California law. References to Your marriage or divorce will include Your registered domestic partnership or dissolution of Your registered domestic partnership.
2) The following is added to the definition of **Surviving Children** in the **Survivor Income Benefit:**
   Surviving Children will also include children of Your California registered domestic partner.

For Indiana residents:

1) The look-back period in the **Pre-Existing Condition Limitation** is changed to 180 days if not already 180 days.
2) The dollar amount stated in the **Claims to be Paid** provision is changed to $5000 if not already $5000.
3) The last sentence in the **Policy Interpretation** provision is deleted and replaced by the following:
   This provision applies only where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1001 et seq.

For Louisiana residents, the following provision is added:

Reinstatement after Military Service: *Can my coverage be reinstated after return from active military service?*
If:

1) Your coverage terminates because You enter active military service; and
2) You are rehired within 12 months of the date You return from active military service;

then coverage may be reinstated, provided You request such reinstatement within 31 days of the date you return to work.

The reinstated coverage will:

1) be the same coverage amounts in force on the date coverage terminated; and
2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
3) be subject to all the terms and provisions of The Policy.

For Massachusetts residents, the following is added to the **Continuation Provisions:**

In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first.

Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

1) 90 days from the date You were no longer eligible for coverage as a Full-time Active Employee;
2) the date You become eligible for similar benefits under another group plan;
3) the last day of the period for which required premium is made;
4) the date the group insurance policy terminates; or
5) the date Your Employer ceases to be a Participant Employer, if applicable.

Continued coverage is subject to all other applicable terms and conditions of The Policy.

For Minnesota residents:

1) the definition of **Any Occupation** is amended by the addition of the phrase “or may reasonably become qualified” to the first line;
2) The first two paragraphs of the **Pre-Existing Conditions Limitation** provision are deleted and replaced by the following:
   No benefit will be payable under The Policy for any Disability that is due to, contributed to by, or results from a Pre-Existing Condition, unless such Disability or loss is incurred:
   1) After the lesser of the last day of:
      a) the number of days stated in Your certificate; or
      b) 730 consecutive days;
      while insured, during which you receive no medical care for the Pre-Existing Condition; or
   2) After the lesser of the last day of:
      a) the number of days stated in Your certificate; or
      b) 730 consecutive days;
      during which you have been continuously insured under The Policy.

   The amount of a benefit increase, which results from a change in benefit options, a change of class or a change in The Policy, will not be paid for any disability that is due to, contributed to by, or results from a Pre-Existing Condition, unless such Disability begins:
   1) After the lesser of the last day of :
      a) the number of days stated in Your certificate; or
      b) 730 consecutive days;
      while insured for the increased benefit amount during which you receive no medical care for the Pre-Existing Condition; or
   2) After the lesser of the last day of :
      a) the number of days stated in Your certificate; or
      b) 730 consecutive days;
      during which you have been continuously insured for the increased benefit amount.
3) The definition of **Pre-existing Condition** in the **Pre-Existing Conditions Limitation** provision is deleted and is replaced by the following:
   Pre-existing Condition means any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse for which You received Medical Care during the lesser of:
   1) the period of time stated in Your certificate; or
   2) the 730 day period;
   that ends the day before:
   1) Your effective date of coverage; or
   2) the effective date of a Change in Coverage.

For Missouri residents:
1) intentionally self-inflicted Injury, suicide or attempted suicide, while sane; or
2) The Arbitration provision is deleted.

For Montana residents:
1) Pregnancy will be covered, the same as any other Sickness, anything in the Policy to the contrary notwithstanding.
2) The Arbitration provision is deleted.

For New Hampshire residents:
1) The definition of **Other Income Benefits** is amended by the deletion of 'mandatory "no-fault" automobile insurance plan';
2) LTD The time period, stated in the **Recurrent Disability** provision, within which a Disability must recur in order to be considered the same Period of Disability is changed to 6 months, if less than 6 months.
3) The **Policy Interpretation** provision is deleted and replaced by the following:
   Under ERISA, the Company is hereby designated by the plan sponsor as a claim fiduciary with discretionary authority to determine eligibility for benefits and to interpret and construe the terms and provisions of the policy. As claim fiduciary, the Company has a duty to administer claims solely in the interest of the participants and beneficiaries of the employee benefit plan and in accordance with the documents and instruments governing the plan. This assignment of discretionary authority does not prohibit a participant or beneficiary from seeking judicial review of the Company's benefit eligibility determination after exhausting administrative remedies. The assignment of discretionary authority made under this provision may affect the standard of review that a court will use in reviewing the appropriateness of the Company's determination. In

order to prevail, a plan participant or beneficiary may be required to prove that the Company's determination was arbitrary and capricious or an abuse of discretion.

4) The time periods stated in the **Claim Appeal** provision are changed to 180 days, if less than 180 days.
5) The Arbitration provision is deleted.

For North Carolina residents:

1) The definition of **Other Income Benefits** is amended by the deletion of 'mandatory "no-fault" automobile insurance plan';
2) The exclusion regarding Workers' Compensation benefits is replaced by the following in the **Exclusions** provision:
   for which the final adjudication or a Workers' Compensation claim determines that benefits are paid, or may be paid, if duly claimed;
3) The **Subrogation** provision is deleted.

For South Carolina residents:

1) The first paragraph of the **Continuity from a Prior Policy** provision is replaced by the following:
   If You become insured under The Policy on the Policy Effective Date and **within 30 days of being covered under the Prior Policy**, the Pre-existing Conditions Limitation will end on the earliest of:
   1) the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
   2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.
2) The time period in the Notice of Claim provision is changed to 20 days, if not already 20 days.
3) The following is added to the Physical Examinations and Autopsy provision: "Such autopsy must be performed during the period of contestability and must take place in the state of South Carolina."

For Utah residents:

1) The time period during which You must be continuously insured in order to exercise the **Conversion Right** is changed to 6 consecutive months, if not already 6 consecutive months.
2) The time period in the **Sending Proof of Loss** provision is changed to 90 days, if not already 90 days.
3) The **Policy Interpretation** provision is deleted and replaced by the following:
   Benefits under this plan will be paid only if We, the plan administrator, decides in Our discretion that you are entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms of conditions of the benefit plan. Determinations made by Us, the plan administrator, pursuant to this reservation of discretion does not prohibit or prevent a claimant from seeking judicial review in federal court or Our determinations.

   The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when you seek judicial review of our determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the plan.

   We are an insurance company that provides insurance of this plan and the federal court will determine the level of discretion that it will accord Our determination.

For Vermont residents:

Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

1) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.
2) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.
3) Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

4) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.
5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

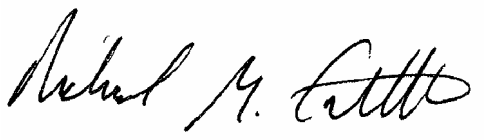
For Washington residents:

1) the term "hyperemesis gravidarum" is deleted from the third paragraph of the definition of **Complications of Pregnancy** and is added to the second paragraph;
2) the **General Work Stoppage** continuation provision is replaced with the following:
   General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage until the last day of the month in which the coverage terminated, but in no event for a period exceeding six months. If the work stoppage ends, this continuation will cease immediately.

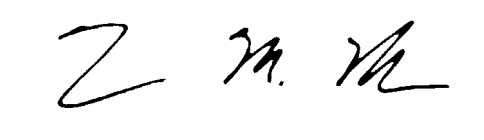
For Wisconsin residents, the time periods stated in the **Claim Appeal** provision are removed.

In all other respects, the Policy and certificates remain the same.

Signed for Hartford Life and Accident Insurance Company



Richard G. Costello, *Secretary*



Thomas M. Marra, *President*

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the

Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   Group Long Term Disability Plan for Employees of CENTRAL MAINE HEALTHCARE CORP..

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2. **Plan Number**

   LTD - 502

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3. **Employer/Plan Sponsor**

   CENTRAL MAINE HEALTHCARE CORP.
   300 Main Street
   Lewiston, ME 04240

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4. **Employer Identification Number**

   01-0386913

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Long Term Disability.

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6. **Plan Administrator**

   CENTRAL MAINE HEALTHCARE CORP.
   300 Main Street
   Lewiston, ME 04240

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7. **Agent for Service of Legal Process**

For the Plan

CENTRAL MAINE HEALTHCARE CORP.
300 Main Street
Lewiston, ME 04240

For the Policy:

Hartford Life and Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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, for example, if it finds your claim is frivolous.

4. 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 (formerly known as the Pension and Welfare Benefits 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.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and

other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet
is Insured by the

Hartford Life and Accident Insurance Company
Simsbury, Connecticut
Member of The Hartford Insurance Group