



Group Long Term Disability Plan

Detroit Medical Center

Policy No. 123080-0001

Underwritten by: Provident Life and Accident Insurance Company

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
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Chattanooga, Tennessee 37402
(423) 294-1011

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE

POLICYHOLDER Detroit Medical Center
4201 St. Antoine
Detroit, MI 48201

POLICY NUMBER 123080-0001

EFFECTIVE DATE July 1, 1997
Revised April 1, 2006


PLAN ANNIVERSARY DATE Each October 1st

JURISDICTION Michigan

We certify that you are covered under a group policy (herein called "Policy") for the coverages indicated on your **Schedule of Insurance**. The Policy is a contract between the Policyholder and Provident Life and Accident Insurance Company. It may be changed or terminated only by those parties alone and constitutes the agreement under which payments are paid.

This Certificate summarizes the provisions of the Policy as they may affect you. It is not the contract of insurance; it is evidence of insurance under the Policy.

In this Certificate "you" and "your" refer to the Covered Person. "We," "us," and "our" mean Provident Life and Accident Insurance Company. Other defined terms appear with their initial letters capitalized. Section headings and references to them appear in boldface type.



**VICE-PRESIDENT, CORPORATE
SECRETARY AND ASSISTANT
GENERAL COUNSEL**



**PRESIDENT AND
CHIEF EXECUTIVE OFFICER**

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SECTION I - INSURING CLAUSE

This Certificate is issued under a Policy that provides income replacement benefits when you become Disabled. Your Disability must commence while the Policy is in effect. When we receive satisfactory Proof of Loss, we will pay long term disability (LTD) monthly benefits according to the terms of the Policy.

SECTION II - SCHEDULE OF INSURANCE

This Schedule of Insurance highlights many of the features of your (LTD) insurance plan. Please refer to the text of each section for full details of coverage.

The following information describes all covered Employers and subsidiaries and identifies the class(es) and schedule(s) in effect under the Policy.

EMPLOYER Detroit Medical Center

SUBSIDIARY NAME None

ELIGIBILITY

To be eligible for coverage, you must (a) apply for coverage under the Policy; (b) be an Eligible Person; and (c) be a member of an Eligible Class.

To be an Eligible Person, you must meet the following requirements:

1. be an employee Actively at Work for the Employer;
2. be regularly scheduled to work at least 30 hours per week;
3. be a citizen or legal resident of the United States, its territories, or Canada;
4. not be a temporary or seasonal employee; and
5. not be a full-time member of the armed forces of any country.

ELIGIBLE CLASS(ES)

All active full-time residents and fellows

CLASS DESCRIPTION(S)

All active full-time residents and fellows

COVERED PERSON

To be a Covered Person under the Policy, you must (a) be an Eligible Person; (b) be accepted for coverage under the Policy; (c) make premium payments when due "if required"; (d) complete the Eligibility Waiting Period; and (e) meet the requirements of **Active Work** and **When Coverage Becomes Effective** in **Section VI - Coverage Provisions**.

CONTRIBUTIONS Employer pays the cost of this insurance.

ELIGIBILITY WAITING PERIOD

You will become covered under the Policy on the Policy's effective date if you are an Eligible Person on that date. Otherwise you will become covered on your first day as an Eligible Person.

If the Policy is a replacement for a Prior Plan, administration of the Eligibility Waiting Period will be modified according to **Replacement of Prior Plans** in **Section VI - Coverage Provisions**.

If your coverage ends, you may request reinstatement of your coverage under the Policy without having to satisfy the Eligibility Waiting Period if:

1. you were previously covered under the Policy;
2. your coverage ended when your lay-off or leave of absence extended beyond the Lay-off or Leave of Absence Period; and
3. you request reinstatement within 12 months of the date on which your coverage ended.

SECTION II - SCHEDULE OF INSURANCE (Continued)

EVIDENCE OF INSURABILITY REQUIREMENTS

You are required to provide Evidence of Insurability when:

1. you apply for coverage under Late Enrollment;
2. your coverage under the Policy ceases and you apply for reinstatement; or
3. you were eligible but not covered under the Prior Plan.

Evidence of Insurability will not be required for employees returning from a family or medical leave.

DISABILITY BENEFITS AND REQUIREMENTS

LTD BENEFIT AMOUNT	Earnings multiplied by the LTD Benefit Percentage, not to exceed the Maximum LTD Monthly Benefit Amount, minus Benefit Offsets	
LTD BENEFIT PERCENTAGE	60%	
	See Disability Benefits Provision for More Information.	
EARNINGS	Earnings means base monthly salary but excludes commissions, bonuses, overtime pay, and any other extra compensation received from the Employer. Earnings are determined as of the date just prior to the Date of Disability.	
MAXIMUM LTD MONTHLY BENEFIT AMOUNT	\$2,500 before reduction by Benefit Offsets	
MINIMUM LTD MONTHLY BENEFIT AMOUNT	The lesser of \$100 or 10% of the LTD Monthly Benefit Amount before reduction for Benefit Offsets	
ELIMINATION PERIOD	180 days	
BENEFIT OFFSETS	Direct Family	
	See Benefit Offsets Provision for More Information.	
MAXIMUM BENEFIT PERIOD	Determined by your age on the Date of Disability:	
GRADED DURATION	AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD
	61 or younger	to age 65
	62	3 years 6 months
	63	3 years
	64	2 years 6 months
	65	2 years
	66	1 year 9 months
	67	1 year 6 months
	68	1 year 3 months
	69 or older	1 year
OWN OCCUPATION PERIOD	2 years	
ANY OCCUPATION PERIOD	From the end of the Own Occupation Period but not exceeding the Maximum Benefit Period	
OWN OCCUPATION INCOME LEVEL	80% of Indexed Earnings	

SECTION II - SCHEDULE OF INSURANCE (Continued)

ANY OCCUPATION INCOME LEVEL	80% of Indexed Earnings from any occupation you are reasonably fitted by education, training, or experience
COVERAGE INCLUDES	Residual
LAY-OFF OR LEAVE OF ABSENCE PERIOD	Not to exceed 2 Weeks
COVERAGE CONTINUED DURING FAMILY OR MEDICAL LEAVE	No
OTHER BENEFITS	
SURVIVOR BENEFIT AMOUNT	A lump sum payment equal to 3 times the LTD Monthly Benefit Amount not reduced by Benefit Offsets
COST OF LIVING ADJUSTMENT (COLA)	
COLA FACTOR	4%
MAXIMUM NUMBER OF ADJUSTMENTS	Up to the Maximum Benefit Period
MAXIMUM ADJUSTED MONTHLY BENEFIT	\$25,000
EXCLUSIONS	
PREEXISTING CONDITION EXCLUSION	Yes; when first covered
PREEXISTING CONDITION PERIOD	The 30 days prior to your coverage effective date
PREEXISTING CONDITION EXCLUSION PERIOD	The first 5 days as a Covered Person
	See Exclusions Provision for More Information.
LIMITATIONS	
MENTAL AND NERVOUS DISORDERS LIMITATIONS	Yes; 24 months of benefits
DRUG AND ALCOHOL DISORDERS LIMITATIONS	Yes; 24 months of benefits
	See Limitations Provision for More Information.

SECTION III - DEFINED TERMS

LIST OF DEFINED TERMS

The page numbers shown below are where each term is defined. For terms defined by an entire section, the page numbers below are those on which the section begins.

Active Work or Actively at Work, 19	Maximum Benefit Period, 9
Any Occupation Disability, 10	Maximum Covered Monthly Earnings, 9
Any Occupation Period, 10	Mental and Nervous Disorders, 17
Benefit Offsets, 13	Noncontributory Insurance, 9
Benefit Period, 12	Own Occupation Disability, 10
Contributory Insurance, 8	Own Occupation Period, 10
CPI-W, 8	Pension Plans, Retirement Plans, and Retirement Benefits, 9
Date of Disability, 10	Physician, 10
Disability, Disabled, 10	Policy, 10
Drug and Alcohol Disorders, 18	Policyholder, 10
Eligibility Waiting Period, 8	Preexisting Condition, 17
Eligible Person, 5	Prior Plan, 10
Elimination Period, 12	Proof of Loss, 22
Employer, 8	Sickness, 10
Evidence of Insurability, 8	Surviving Children, 15
Hospital, 8	Surviving Spouse, 15
Indexed Earnings, 9	War, 17
Injury, 9	Work Earnings, 10
Late Enrollment, 9	
LTD Monthly Benefit, 9	

CONTRIBUTORY INSURANCE means that coverage purchased under the Policy is paid for in full or in part by you.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. When required, we will obtain prior state approval of the new index.

ELIGIBILITY WAITING PERIOD means the period you must wait before coverage becomes effective under the Policy. (See **Section II - Schedule of Insurance**.)

EMPLOYER means the Policyholder and all subsidiaries named on the **Schedule of Insurance**.

EVIDENCE OF INSURABILITY means you must:

1. complete and sign our health and medical history form(s);
2. sign our form authorizing us to obtain information about your health and medical history;
3. at your expense, undergo a physical examination, if required by us, which may include blood testing; and
4. at your expense, provide any additional information about your insurability that we may reasonably require.

HOSPITAL means a legally operated institution or facility providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians and registered nurses. Nursing homes, rest homes, convalescent homes, homes for the aged, and facilities primarily providing custodial, educational, or rehabilitative care are not Hospitals.

SECTION III - DEFINED TERMS (Continued)

INDEXED EARNINGS means your Earnings adjusted by the rate of increase in the CPI-W. During the first year of Disability, your Indexed Earnings are the same as your Earnings. After that, the Indexed Earnings are determined on each anniversary of your Date of Disability by increasing the previous year's Indexed Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Indexed Earnings will not decrease even if the CPI-W decreases.

INJURY means an accidental bodily injury requiring treatment by a Physician.

LATE ENROLLMENT means you have applied for Contributory coverage 31 days or more after the date you first became an Eligible Person.

LTD MONTHLY BENEFIT means the monthly benefit payable under the terms of the Policy.

MAXIMUM BENEFIT PERIOD means the longest period for which LTD Monthly Benefits are payable for any one period of continuous Disability. The Maximum Benefit Period will begin to accrue when the Elimination Period ends. LTD Monthly Benefits are not payable after the end of the Maximum Benefit Period even if you are still Disabled. (See **Section II - Schedule of Insurance**.)

MAXIMUM COVERED MONTHLY EARNINGS means the Maximum LTD Monthly Benefit divided by the LTD Benefit Percentage.

NONCONTRIBUTORY INSURANCE means coverage purchased under the Policy is paid for in full by the Policyholder.

PENSION PLANS, RETIREMENT PLANS, and RETIREMENT BENEFITS mean money paid to a fund by the Employer on your behalf that is later received by you at the time of your retirement and

1. is established for the purpose of providing a source of retirement income; and
2. does or does not result in a reduction of the amount of money you would receive when Disabled under the plan at your normal retirement age.

The terms Retirement Plan and Pension Plan include any Retirement Benefit:

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

The terms Retirement Plan or Pension Plan do not include:

1. a profit-sharing plan;
2. a thrift plan;
3. an individual retirement account (IRA);
4. a tax-sheltered annuity (TSA);
5. a stock-ownership plan; or
6. a non-qualified plan of deferred compensation.

Regardless of your retirement date when Disabled, you may be receiving Retirement Benefits. Retirement Benefits will be treated as a Benefit Offset on the later of the following:

1. when you attain age 62; or
2. when you attain your normal retirement date.

Retirement Benefits received voluntarily by you when Disabled prior to your normal retirement date will be treated as a Benefit Offset at the time they are received.

The Benefit Offset will not exceed the percentage being contributed to your Retirement or Pension Plan by the Employer immediately prior to the Date of Disability.

Retirement Benefits may be paid in either a lump sum or in periodic payments. Your Benefit Offsets will be adjusted according to the manner in which your Retirement Benefits are paid. (See **Benefit Offsets** in **Section IV - Benefit Provisions**.)

SECTION III - DEFINED TERMS (Continued)

PHYSICIAN means a licensed medical professional, diagnosing and treating you within the scope of the physician's medical license. A Physician does not include yourself or anyone related to you by blood, marriage, or adoption.

POLICY means the group LTD Insurance Policy issued by us to the Policyholder and identified by the policy number.

POLICYHOLDER means the entity named on the face page of the Policy.

PRIOR PLAN means the Employer's group long term disability insurance policy in effect on the day before the effective date of the replacement coverage under the Policy.

SICKNESS means an illness or disease, including pregnancy or complications of pregnancy, requiring treatment by a Physician.

WORK EARNINGS means your earnings from self-employment or earnings from work performed for the Employer or any other employer while Disabled.

DEFINITIONS OF DISABILITY

You are Disabled if due to your Sickness or Injury you meet the following definition(s) of Disability:

OWN OCCUPATION DISABILITY DEFINITION

During the Own Occupation Period, you are Disabled from your Own Occupation if due to your Sickness or Injury you:

1. are unable to earn at least the Own Occupation Income Level; or
2. are unable to perform each of the material duties of the occupation that you regularly perform for the Employer or, if a physician or an attorney, unable to perform each of the material duties of your specialty in the practice of medicine or law.

You will not be considered Disabled if you have Work Earnings in excess of the Own Occupation Income Level shown in **Section II - Schedule of Insurance**.

ANY OCCUPATION DISABILITY DEFINITION

During the Any Occupation Period, you are Disabled from Any Occupation if due to your Sickness or Injury you:

1. are unable to earn at least the Any Occupation Income Level while working in any occupation; or
2. are unable to perform each of the material duties of any occupation for which you are reasonably fitted by education, training, or experience.

You will not be considered Disabled if you have Work Earnings in excess of the Any Occupation Income Level shown in **Section II - Schedule of Insurance**.

The Date of Disability is the date on which you first meet the Own Occupation or Any Occupation Disability Definition.

OWN OCCUPATION PERIOD

The Own Occupation Period starts on the date that LTD Benefits become payable and continues until you have been Disabled for the duration shown under Own Occupation Period in **Section II - Schedule of Insurance**.

ANY OCCUPATION PERIOD

The Any Occupation Period starts on the day following expiration of the Own Occupation Period and continues up to, but not in excess of, the Maximum Benefit Period.

SECTION IV - BENEFIT PROVISIONS

LTD MONTHLY BENEFIT AMOUNT

BENEFITS PAYABLE WHEN DISABLED AND NOT WORKING

When you are Disabled and do not have Work Earnings, your LTD Monthly Benefit Amount will be the lesser of:

1. Earnings multiplied by the LTD Benefit Percentage; or
2. the Maximum LTD Monthly Benefit Amount shown in **Section II - Schedule of Insurance**.

The applicable amount above will then be reduced by Benefit Offsets.

BENEFITS PAYABLE WHEN DISABLED AND WORKING

When you are Disabled and have Work Earnings, your LTD Monthly Benefit will be calculated as follows:

$$\text{LTD Benefit Amount} \times \frac{\text{Indexed Earnings} - \text{Work Earnings}}{\text{Indexed Earnings}}$$

Any LTD Monthly Benefit paid for a period of less than a full month will be the amount of the LTD Monthly Benefit Amount multiplied by the number of days Disabled and divided by 30.

The LTD Monthly Benefit Amount, Maximum LTD Monthly Benefit Amount, and Minimum LTD Monthly Benefit Amount are shown in **Section II - Schedule of Insurance**.

The LTD Monthly Benefit Amount will be determined according to benefit amounts in force under the Policy for you as of the Date of Disability. (See **Section II - Schedule of Insurance**.)

The LTD Monthly Benefit Amount will not be paid:

1. in excess of the Maximum LTD Monthly Benefit Amount;
2. in an amount less than the Minimum LTD Monthly Benefit Amount;
3. during the Elimination Period;
4. for any period in excess of the Maximum Benefit Period; or
5. when you are Disabled and earning more than the occupation income level(s) shown in **Section II - Schedule of Insurance**.

If the Policy is a replacement for a Prior Plan, administration of this LTD Monthly Benefit Amount provision may be modified according to **Replacement of Prior Plans** in **Section VI - Coverage Provisions**.

WHEN LTD MONTHLY BENEFITS BEGIN

LTD Monthly Benefits will be payable on the first day after satisfaction of the Elimination Period.

MINIMUM LTD MONTHLY BENEFIT AMOUNT

When benefits are payable, the LTD Monthly Benefit Amount will not be less than the Minimum LTD Monthly Benefit Amount shown in **Section II - Schedule of Insurance**.

WHEN LTD MONTHLY BENEFITS END

LTD Monthly Benefits will automatically end on the earliest of the following when you:

1. are no longer Disabled;
2. fail to provide satisfactory proof of continuing Disability;
3. continue to be Disabled beyond the Maximum Benefit Period;
4. refuse to cooperate or to participate in a program of rehabilitation approved by us;
5. die; or
6. temporarily return to Active Work and are covered or eligible for coverage under any other group LTD policy.

(See **Effect of a Temporary Return to Active Work** in this **Section IV - Benefit Provisions**.)

SECTION IV - BENEFIT PROVISIONS (Continued)

BENEFITS AFTER COVERAGE ENDS OR IS CHANGED

Your right to receive LTD Monthly Benefits for a Disability that begins while you are covered is not affected by:

1. termination of the Policy after you become Disabled;
2. termination of your coverage while the Policy remains in force; or
3. adoption of amendment(s) approved after your Date of Disability.

ELIMINATION PERIOD

The Elimination Period is the length of time prior to benefits being payable during which you are continuously Disabled. The Elimination Period starts on the Date of Disability and continues for the duration shown in **Section II - Schedule of Insurance**. The Elimination Period may be satisfied while you are Disabled and working.

A new Elimination Period will be applied to each Disability. If you are not continuously Disabled during the Elimination Period, the **Temporary Return to Active Work** provision under this **Section IV - Benefit Provisions** may apply.

BENEFIT PERIOD

The Benefit Period is the length of time during which benefits are payable. You must be continuously Disabled during the Benefit Period to receive benefits under the Policy.

TEMPORARY RETURN TO ACTIVE WORK

If you temporarily return to Active Work while Disabled, the following provisions may apply:

TEMPORARY RETURN TO ACTIVE WORK ALLOWABLE PERIODS

1. If you temporarily return to Active Work while satisfying your Elimination Period, the following will apply:
 - a. the allowable period of a temporary return to Active Work will be calculated as 5 days for each 30 days of required Elimination Period;
 - b. the allowable period of a temporary return to Active Work may not exceed 30 days; and
 - c. if after having returned to Active Work, you become Disabled again and the return to Active Work did not exceed the allowable periods previously described, then you will not be subject to the requirements of a new Elimination Period.
2. If you temporarily return to Active Work during a Benefit Period, the following will apply:
 - a. the allowable period of a temporary return to Active Work may not exceed a total of 180 days; and
 - b. if after having returned to Active Work, you become Disabled again from the same or related cause or causes and your return to Active Work did not exceed the allowable period described above, then your Disability will be considered a continuation of the Benefit Period.

SECTION IV - BENEFIT PROVISIONS (Continued)

EFFECT OF A TEMPORARY RETURN TO ACTIVE WORK

If you temporarily return to Active Work and do not exceed the allowable period, the following will apply to the payment of benefits:

1. the duration of your temporary return to Active Work will not be used to satisfy the Elimination Period or any of the occupational periods described in the **Definitions of Disability** in **Section III - Defined Terms**;
2. the LTD Monthly Benefit Amount will not be payable during a temporary return to Active Work;
3. during a period in which you temporarily return to Active Work, coverage under the Policy will automatically end on the date you become covered or eligible for coverage under any other group policy;
4. the provisions of the Policy will be applied to benefits in the same manner as they would have been applied had there been no interruption in the Elimination Period or Benefit Period; and
5. any change in your Earnings during the time you temporarily return to Active Work will not be used to determine your LTD Monthly Benefit Amount if your Benefit Period resumes.

BENEFIT OFFSETS

Benefit Offsets means the following:

1. sick pay from the Employer;
2. salary continuation or severance pay from the Employer, excluding vacation pay;
3. any amount you receive or are eligible to receive because of your Disability under any Workers' Compensation law or similar law, including amounts for vocational therapy or for partial or total disability, whether permanent or temporary;
4. any amount you receive or are eligible to receive because of Disability under any state disability income benefit law or similar law;
5. any amount you receive or are eligible to receive because of Disability under any group insurance coverage;
6. any Disability or Retirement Benefits, sponsored or contributed to by the Employer on your behalf, that are received under the Employer's Retirement Plan (in addition, see **Pension Plans, Retirement Plans, and Retirement Benefits** in **Section III - Definitions and List of Defined Terms**);
7. any amount you receive or are eligible to receive through the Veterans Administration (except from a National Service Life Insurance Policy) because of your Disability;
8. any amount you receive by compromise, settlement, or other method resulting from a claim for any of the above, whether disputed or undisputed;
9. if the Benefit Offsets are shown as Direct Primary on the **Schedule of Insurance**, then any amount you receive or are eligible to receive because of your Disability or retirement under any Federal Act or Plan;
10. if the Benefit Offsets are shown as Direct Family on the **Schedule of Insurance**, then any amount you, your spouse, or children under age 18 receive or are eligible to receive because of your Disability or retirement under any Federal Act or Plan; and
11. if the Benefit Offsets are shown as All Sources on the **Schedule of Insurance**, the LTD Monthly Benefit Amount equals the lesser of:
 - a. Earnings multiplied by the LTD Benefit Percentage before reduction for Benefit Offsets;
 - b. the LTD Maximum Monthly Benefit Amount; or
 - c. the All Sources percentage multiplied by your Earnings less Benefit Offsets.

SECTION IV - BENEFIT PROVISIONS (Continued)

Federal Acts and Plans mean any of the following:

- a. the Federal Social Security Act;
- b. the Canada Pension Plan;
- c. the Quebec Pension Plan;
- d. the Railroad Retirement Act;
- e. the Jones' Act; or
- f. any similar plan or act.

EXCEPTIONS TO BENEFIT OFFSETS

Benefit Offsets do not include the following:

1. any cost of living increase in any Benefit Offset if the increase becomes effective while you are Disabled and eligible for that Benefit Offset;
2. reimbursement for hospital, medical, or surgical expense;
3. reimbursement for reasonable attorney's fees incurred due to a claim for Benefit Offsets;
4. early Retirement Benefits under the Federal Social Security Act that are not received;
5. if the Benefit Offsets are shown as Direct Primary on the **Schedule of Insurance**, then benefits received under the Federal Social Security Act by your spouse or children under age 18;
6. group credit or mortgage disability insurance benefits;
7. the following amounts under the Employer's Retirement Plan:
 - a. any amount that is attributable to your contributions to the plan; or
 - b. any amount you receive upon termination of employment without being disabled or retired; and
8. benefits from (a) through (h) as follows:
 - a. profit-sharing plan;
 - b. thrift or savings plan;
 - c. deferred compensation plan;
 - d. plans under IRC Section 401(k) or 457;
 - e. individual retirement account (IRA);
 - f. tax-sheltered annuity (TSA) under IRC Section 403(b);
 - g. no fault auto insurance; or
 - h. individual disability insurance.

RULES FOR BENEFIT OFFSETS

LUMP SUM PAYMENTS

When you negotiate a lump sum settlement under any act or law referred to in this Benefit Offset provision, we will divide the lump sum settlement by the lesser of the schedule under state law or the remaining number of months under the Maximum Benefit Period.

See **Pension Plans, Retirement Plans, and Retirement Benefits** in **Definitions** in **Section III - Defined Terms** for further information.

PENDING BENEFIT OFFSETS

During the period between the date you apply for Social Security benefits and the date such benefits are actually granted or denied, you must select one of the following options:

1. elect to have the LTD Monthly Benefit Amount reduced by an estimate of your expected Social Security benefit; or
2. elect to have no reduction made until the date Social Security benefits are actually granted.

If you elect option 1, your LTD Monthly Benefit Amount will be adjusted after Social Security benefits are determined.

If you elect option 2, you must sign an agreement promising to repay any overpayment caused by Social Security benefits being paid. This overpayment must be reimbursed to us on the date Social Security benefits are actually paid.

SECTION IV - BENEFIT PROVISIONS (Continued)

If benefits are denied under the Social Security Act, Railroad Retirement Act, or any plan or act of like intent of a foreign nation, you must file for a request for reconsideration. If denied again, you must request a hearing before an Administrative Law Judge unless waived in writing by us.

Your LTD Monthly Benefit Amount will be adjusted as if you had elected option 1 when you do not:

1. elect one of the above options;
2. file a request for reconsideration; or
3. request a hearing before an Administrative Law Judge.

OVERPAYMENT OF CLAIMS

If after having made one or more payments under the Policy, we find that the amount of benefits or payments from other sources that we should have considered in computing the amount of your claim is greater or less than what was considered, we will adjust claim payments in the following manner:

1. if we have underpaid benefits, we will pay the amount necessary to adjust the total payments to the amount that we should have paid; or
2. if we have overpaid benefits, the overpayment must be refunded to us by you.

We may reduce or eliminate future payments instead of requiring repayment in one sum. The Minimum LTD Monthly Benefit will not be paid while the overpayment is being repaid.

COST OF LIVING ADJUSTMENT (COLA)

After you have been Disabled and have received LTD Monthly Benefits for 12 consecutive months, your LTD Monthly Benefit Amount will receive a Cost of Living Adjustment on each anniversary of the date LTD Monthly Benefits began.

Adjustments will end on the earlier of the following:

1. the date the Maximum Benefit Period is satisfied;
2. the date you cease to be Disabled;
3. the date you cease to provide satisfactory proof of ongoing Disability; or
4. the date the number of adjustments made exceed the Maximum Number of Adjustments shown in **Section II - Schedule of Insurance**.

The LTD Monthly Benefit Amount will be adjusted by multiplying it by the COLA Factor shown in **Section II - Schedule of Insurance**.

SURVIVOR BENEFIT

If you die while LTD Monthly Benefits are payable, we will pay a Survivor Benefit. The Survivor Benefit will be paid according to the following:

1. the Survivor Benefit amount shown on the **Schedule of Insurance** will be paid to your Surviving Spouse;
2. if you do not have a Surviving Spouse, but do have Surviving Children, we will pay this benefit to your estate;
3. the Survivor Benefit will not be paid if you do not have a Surviving Spouse or Surviving Children; and
4. Survivor Benefits, if payable, will first be applied to reduce any claim overpayments.

Surviving Spouse means your legal spouse who meets all requirements for a valid legal marriage in your and your Surviving Spouse's state of residence.

Surviving Children means your natural or adopted children who are:

1. unmarried; and
2. under the age of twenty-five (25).

SECTION IV - BENEFIT PROVISIONS (Continued)

WAIVER OF PREMIUM

Your coverage will continue without payment of premiums while LTD Monthly Benefits are payable.

SECTION V - EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

WAR

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared War, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

INTENTIONALLY SELF-INFLICTED INJURY

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

RIOT OR CIVIL INSURRECTION

You are not covered for a Disability caused or contributed to by your active participation in an insurrection, rebellion, or riot.

COMMISSION OF A FELONY

You are not covered for a Disability caused or contributed to by your commission of or attempt to commit a felony.

INCARCERATION

Benefits under the Policy will not be payable when you are incarcerated for any period exceeding 90 days.

ARMED FORCES

You are not covered for a Disability caused or contributed to by service in the armed forces as an active member or as a reservist of any country.

PREEXISTING CONDITION

A Disability caused or contributed to by a Preexisting Condition is not covered under the Policy unless the Date of Disability occurs after the Preexisting Condition Exclusion Period shown in **Section II - Schedule of Insurance**.

Preexisting Condition means a mental or physical condition for which you have (a) consulted a Physician; (b) received medical treatment or services; or (c) taken prescribed drugs or medications during the Preexisting Condition Period shown in **Section II - Schedule of Insurance**.

If the Policy is a replacement for a Prior Plan, administration of this Preexisting Condition provision may be modified according to **Replacement of Prior Plans** in **Section VI - Coverage Provisions**.

LIMITATIONS

FOREIGN MEDICAL TREATMENT

You are not eligible for benefits during any period of Disability in which you are hospitalized or are receiving medical treatment outside the United States, its territories, or Canada.

MENTAL AND NERVOUS DISORDERS

Payment of LTD Monthly Benefits is limited to the duration shown in **Section II - Schedule of Insurance** for each Disability caused or contributed to, directly or indirectly, by a Mental or Nervous Disorder. If you are confined in a Hospital at the end of the duration, this limitation will not apply while you are continuously confined.

Mental and Nervous Disorders mean physical, mental, emotional, behavioral, or stress-related disorders caused or contributed to, directly or indirectly, by a mental or nervous condition, as classified in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) in effect as of the Date of Disability.

SECTION V - EXCLUSIONS AND LIMITATIONS (Continued)

DRUG AND ALCOHOL DISORDERS

Payment of LTD Monthly Benefits is limited to the duration shown in **Section II - Schedule of Insurance** for each Disability caused or contributed to, directly or indirectly, by a Drug or Alcohol Disorder. If you are confined in a Hospital at the end of the duration, this limitation will not apply while you are continuously confined.

Drug or Alcohol Disorders mean physical, mental, emotional, behavioral, or stress-related disorders caused or contributed to, directly or indirectly, by substance abuse or dependency as classified in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) and/or the International Classification of Diseases (ICD) in effect as of the Date of Disability.

In no case will LTD Monthly Benefits be paid beyond the original Maximum Benefit Period shown in **Section II - Schedule of Insurance**.

SECTION VI - COVERAGE PROVISIONS

ACTIVE WORK PROVISIONS

ACTIVE WORK OR ACTIVELY AT WORK DEFINITION

Active Work and Actively at Work mean that you are performing each of the material duties of the occupation that you regularly perform for the Employer at the Employer's usual place of business.

ACTIVE WORK REQUIREMENTS

If you are absent from Active Work because of Sickness or Injury on the day before the scheduled effective date of your coverage, your coverage will not become effective until the day after you complete one full day of Active Work as an Eligible Person.

CHANGES IN BENEFITS

This Active Work requirement also applies to any change in benefits. If you return to Active Work during a Benefit Period (see **Benefit Periods** in **Section IV - Benefit Provisions**), you will not qualify for any change in benefits caused when:

1. your status as a Covered Person of a class changes;
2. your Earnings change; or
3. the terms of the Policy change.

EXCEPTIONS

The Active Work Requirement will be waived when you:

1. are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day;
2. were Actively at Work on your last scheduled work day before the date of your absence; and
3. were capable of Active Work on the day before the scheduled effective date of your coverage.

WHEN COVERAGE BECOMES EFFECTIVE

NONCONTRIBUTORY INSURANCE

Subject to the Active Work Provisions, Noncontributory Insurance becomes effective on the date you become eligible for coverage under the Policy.

CONTRIBUTORY INSURANCE

If you apply for Contributory Insurance within the first 31 days of becoming eligible, you will not be required to provide Evidence of Insurability. However, if you apply after the first 31 days in which you become eligible, you must provide Evidence of Insurability. Subject to the Active Work Provisions, your Contributory Insurance coverage becomes effective on one of the following dates:

1. the date you become eligible if you apply on or before that date;
2. the date you apply if you apply within 31 days after you become eligible; or
3. the date we approve your Evidence of Insurability if you apply more than 31 days after you become eligible.

COVERAGE SUBJECT TO EVIDENCE OF INSURABILITY

Coverage subject to Evidence of Insurability becomes effective on the later of:

1. your effective date of coverage; or
2. the date we approve your Evidence of Insurability.

Coverage subject to Evidence of Insurability is also subject to the **Active Work Provisions** in this **Section VI - Coverage Provisions**.

SECTION VI - COVERAGE PROVISIONS (Continued)

WHEN COVERAGE ENDS

TERMINATION OF STATUS AS A COVERED PERSON

Your coverage will automatically cease under the Policy on the earliest of the following:

1. the date you cease to make premium contributions if your coverage is Contributory;
2. the date the Policy terminates;
3. the date your employment with the Employer terminates;
4. the date on which you cease to meet the requirements shown in **Section II - Schedule of Insurance**;
5. the date on which you cease to be a member of an Eligible Class;
6. the date on which your lay-off or leave of absence exceeds the period shown in the **Schedule of Insurance** under Lay-off or Leave of Absence Period; or
7. if you are a legal resident, the date on which you have been residing outside the United States, its territories, or Canada for a period of 6 or more consecutive months.

CONTINUATION AS A COVERED PERSON

Status as a Covered Person and coverage under the Policy will continue:

1. while you are Disabled; or
2. during the Lay-off or Leave of Absence Period shown in the **Schedule of Insurance**.

REINSTATEMENT OF COVERAGE

You may request reinstatement if your coverage under the Policy ended due to any of the following reasons:

1. you were unable to meet the eligibility requirements of your insured class;
2. you failed to make a required premium contribution; or
3. your coverage ended during a leave of absence under the terms of any state or federally mandated family or medical leave act or law.

You must request reinstatement within 90 days of ceasing to be a Covered Person. Evidence of Insurability will not be required for reinstatements following your return from a family or medical leave. Evidence of Insurability is required for all other reinstatement requests.

If coverage is reinstated, the following will apply:

1. the Eligibility Waiting Period will be waived; and
2. the applicable Preexisting Conditions provision in **Section V - Exclusions and Limitations** will be applied as if there were no interruption in coverage.

REPLACEMENT OF PRIOR PLANS

Replacement of a Prior Plan with the Policy may result in some of our provisions being modified. When the Policy replaces a Prior Plan, we will modify our provisions as indicated in the following description of effects. The provisions affected by these modifications include but are not limited to the following:

EFFECT ON ELIGIBILITY WAITING PERIOD

If you were covered under the Prior Plan on the day before the effective date of the Policy, your Eligibility Waiting Period may be waived as of the Policy effective date. If you were previously declined for LTD insurance, you must, for Contributory Insurance, submit Evidence of Insurability satisfactory to us before you can become covered under the Policy. (See **Section II - Schedule of Insurance** and **Section III - Definitions**.)

SECTION VI - COVERAGE PROVISIONS (Continued)

EFFECT ON PREEXISTING CONDITIONS

If your Disability is subject to the Preexisting Condition Exclusion in **Section V - Exclusions and Limitations**, LTD Monthly Benefits will be payable if:

1. you were covered under the Prior Plan on the day before the effective date of your Employer's coverage under the Policy;
2. you were continuously covered under the Policy from the effective date of the Employer's coverage under the Policy through the date you became Disabled from the Preexisting Condition; and
3. benefits would have been payable under the Prior Plan if it had remained in force, taking into account the preexisting condition limitation or exclusion, if any, of the Prior Plan.

EFFECT ON LTD MONTHLY BENEFITS

The LTD Monthly Benefit will be the lesser of:

1. the monthly benefit that would have been payable under the terms of the Prior Plan if it had remained in force; or
2. the LTD Monthly Benefit amount payable under the Policy.

EFFECT ON WHEN LTD MONTHLY BENEFITS END

If the Policy is a replacement of a Prior Plan, then LTD Monthly Benefits will automatically end when the earlier of the following occurs:

1. the events listed under **When LTD Monthly Benefits End** in **Section IV - Benefits Provision** of the Policy; or
2. the date on which your benefits under the Prior Plan would have ended if it had remained in force.

SECTION VII - CLAIM PROVISIONS

GENERAL CLAIM PROVISIONS

FILING A CLAIM

Claims should be filed on our forms. If you do not receive our forms within 15 days after you ask for them, you may submit your claims in a letter to us. The letter should include the Date of Disability and the cause and nature of the Disability.

PROOF OF LOSS

Proof of Loss means written evidence satisfactory to us that you are Disabled and entitled to LTD Monthly Benefits. Proof of Loss must be provided at your expense.

TIME LIMITS ON FILING PROOF OF LOSS

You must give us Proof of Loss within 90 days after the end of the Elimination Period. If you cannot do so, you must give it to us when reasonably possible, but no later than 1 year after that 90-day period. If Proof of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

DOCUMENTATION

At your expense, you must submit completed claim statements, a signed authorization for us to obtain information, and any other items we may require in support of your claim. If you do not provide the documentation within 60 days after we mail you our request, your claim may be denied or suspended.

INVESTIGATION OF CLAIM

We may investigate your claim at any time. At our expense, we may have you examined at reasonable intervals by specialists of our choice including physicians, psychologists, psychiatrists, or vocational evaluators. We may deny or suspend LTD Monthly Benefits if you fail to attend an examination or cooperate with the examiner.

TIME OF PAYMENT

We will pay LTD Monthly Benefits within 60 days after the Proof of Loss has been satisfied. LTD Monthly Benefits will be paid to you at the end of each month during which you qualify. LTD Monthly Benefits remaining unpaid at the time of your death will be paid to your estate.

NOTICE OF DECISION ON CLAIM

You will receive a written decision on your claim within a reasonable time after we receive your claim. If you do not receive our decision within 90 days after we receive your claim, you will have an immediate right to request a review as if your claim had been denied. If we deny any part of your claim, you will receive a written notice of denial containing the following information:

1. the reason for our decision;
2. reference to the parts of the Policy on which our decision is based;
3. a description of any additional information needed to support your claim; and
4. information concerning your right to a review of our decision.

REVIEW PROCEDURES

You may request in writing review of a denial of your claim within 60 days after you receive notice of denial. When you request a review, you may send us written comments or other items to support your claim. You may review any nonprivileged information that relates to your request for review.

We will review your claim promptly after we receive your request. We will send you a notice of our decision within 60 days after we receive your request, or within 120 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant parts of the Policy.

SECTION VII - CLAIM PROVISIONS (Continued)

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof of Loss and have exhausted all appeals. Such action may not be brought more than 3 years after the earlier of:

1. the date we receive Proof of Loss; or
2. the end of the period within which Proof of Loss is required to be given.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following information with the information contained in the preceding Certificate of Insurance comprises a portion of the Summary Plan Description under the Employee Retirement Security Act of 1974 (ERISA) only for the benefits described in the preceding Certificate of Insurance.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST SCHEDULE OF INSURANCE CHANGE

The Employer can request a Schedule of Insurance change. Only an officer or registrar of Provident Life and Accident can approve a change. The change must be in writing and endorsed on or attached to the Schedule of Insurance.

TERMINATION BY THE EMPLOYER

The Employer may terminate this Policy by giving us a 31-day advance written notice. The effective date of termination will be the later of the following:

1. the date stated in the notice; or
2. the date we receive the notice.

TERMINATION BY PROVIDENT

Provident may terminate this Policy with advance written notice. The minimum advance notice of termination shall be 31 days. Failure to receive the written notice will not waive our rights under this provision..

Provident has the right to terminate the Policy if:

1. less than 100% of Eligible Persons are insured for any Noncontributory benefit;
2. fewer than 25 employees are insured;
3. the Employer does not report all employees who are eligible for insurance under the Policy; or
4. the Employer fails, at any time:
 - a. to furnish promptly any information Provident reasonably may require including occupational information and any other information that may be required to manage a claim; or
 - b. to perform any other obligations pertaining to the Policy which includes making available for review Employer records that have a bearing on the Policy.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your group insurance certificate. Provident Life and Accident must receive a completed claim form. The form must be completed by you, your authorized representative, your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Provident Life and Accident directly.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

CLAIMS PROCEDURES

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

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

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

APPEAL PROCEDURES

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

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

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

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

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a civil suit under federal law;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- 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.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

Assistance with Your Questions

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

DISCRETIONARY ACTS

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

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