Champlain College, Inc.

Your Group Long Term Disability Plan

Policy No. 342361.011

Underwritten by Unum Life Insurance Company of America

08-2012

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CERTIFICATE OF COVERAGE

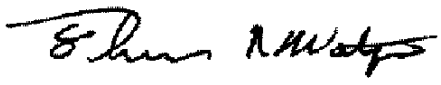
Unum Life Insurance Company of America (referred to as "we," "our" and "us") welcomes your employer as a client.

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

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

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

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



President

PLAN OUTLINE

Description of Eligible Classes

All Employees

Amount of Insurance

- 66 2/3% (benefit percentage) of basic monthly earnings not to exceed the maximum monthly benefit, less other income benefits.

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

- The maximum monthly benefit is $15,000.

- The minimum monthly benefit is the greater of:

  1. $100.00; or
  2. 10% of the monthly benefit before deductions for other income benefits.

Maximum Benefit Period

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

Elimination Period:

- 180 days

Minimum Requirement for Active Employment: 37.5 hours per week

Definition of Basic Monthly Earnings

"Monthly Earnings" means your gross monthly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, course overloads, stipends and any other extra compensation, or income received from sources other than your Employer.

Waiting Period:

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

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

Contributions

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

Changes Effective

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

Continuation of Your Insurance During Certain Absences

Type of Absence	Time Limit
Temporary Layoff or Unpaid Leave of Absence	To the end of the policy month following the policy month in which the layoff or leave of absence begins.
Paid Leave of Absence	Continuation for up to 6 months
Sabbaticals	Continuation for up to 12 months

Discretionary Authority

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

TERMS YOU SHOULD KNOW

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

- "Active employment" means you must be working:
  1. for your employer on a full-time basis and paid regular earnings (temporary or seasonal employees are excluded);
  2. at least the minimum number of hours shown in the plan outline; and either
  3. at your employer's usual place of business; or
  4. at a location to which your employer's business requires you to travel.

- "Basic monthly earnings" - as defined in the plan outline.

- "Disability" or "disabled" - see the end of these terms.

- "Disability benefits," when used with the term retirement plan, means money which:

  1. is payable under a retirement plan due to disability as defined in that plan; and

  2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as explained in this certificate of coverage.)

- "Eligibility date" means the date you become eligible for insurance after completing the waiting period shown in the plan outline.

- "Elimination period" means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the plan outline and begins on the first day of disability.

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

- "Employer" means the policyholder and includes any division, any subsidiary or any affiliated company named in the policy.

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

- "Gross monthly benefit" means your benefit amount before any reduction for other income benefits and earnings.
- "Home office" means the Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

- "Indexed pre-disability earnings" means your basic monthly earnings in effect just prior to the date your disability began adjusted on the first anniversary of benefit payments and each following anniversary. Each adjustment will be based on the lesser of 10% or the current annual percentage increase in the Consumer Price Index.

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

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

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

- "Physician" means a person who is:

  1. operating within the scope of his license; and either

  2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or

  3. legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

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

- "Retirement benefits," when used with the term retirement plan, means money which:

  1. is payable under a retirement plan either in a lump sum or in the form of periodic payments;

  2. does not represent contributions made by you (payments which represent your contributions are deemed to be received over your expected remaining life regardless of when such payments are actually received); and

  3. is payable upon:
     a. early or normal retirement; or
     b. disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

- "Retirement plan" means a plan which provides your retirement benefits and which is not funded wholly by your contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

- "Sickness" means illness, disease or pregnancy. Disability must begin while you are insured under the policy.

- "Waiting period," as shown in the plan outline, means the continuous length of time you must serve in an eligible class to reach your eligibility date.

- "You" and "your" means you, the employee.

- "Disability" and "disabled" mean that because of injury or sickness:

    1. you cannot perform each of the material duties of your regular occupation; or

    2. you, while unable to perform all of the material duties of your regular occupation on a full-time basis, are:

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

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

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

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

ENROLLMENT AND DATE INSURANCE STARTS

When can you enroll?
You can enroll if you are:

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

When does insurance start?
Insurance will start at 12:01 a.m. on the day determined as follows, but only if you enroll for insurance with us through your employer on a form satisfactory to us.

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

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

DISABILITY

When do disability benefits become payable?
We will pay you a monthly benefit after the end of the elimination period when we receive proof that you:

1. are disabled due to sickness or injury; and

2. require the regular attendance of a physician.

But, if you are disabled due to a pre-existing condition, we will pay you on the later of:

1. the end of the elimination period; or

2. 24 months after you become insured.

A "pre-existing condition" means any sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines within 6 months prior to your effective date.

What conditions must be met for benefit payments to continue?
We will pay you as long as you remain disabled and require the regular attendance of a physician. But we will not pay any longer than the maximum benefit period shown in the plan outline.

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

How is the benefit figured?

To figure the amount of your monthly benefit:

1. Take the lesser of:

   a. 66 2/3% of your basic monthly earnings; or
   b. the amount of the maximum monthly benefit shown in the plan outline; and

2. Deduct other income benefits from this amount.

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

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

2. After 12 months, the following formula will be used to figure the monthly benefit.

   (A divided by B) x C

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

   B = Your "indexed pre-disability earnings".

   C = The benefit as figured above, but not including adjustments under the Cost of Living Adjustment provision.

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

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

What are "other income benefits"?
Other income benefits means those benefits as follows:

1. The amount for which you are eligible under:

   a. Workers' or Workmen's Compensation Law;
   b. occupational disease law; or
   c. any other act or law of like intent.

2. The amount of any disability income benefits for which you are eligible under any compulsory benefit act or law.

3. The amount of any disability income benefits for which you are eligible under:

   a. any other group insurance plan;
   b. any governmental retirement system as a result of your job with your employer.

4. The amount of disability benefits and/or retirement benefits you receive under your employer's retirement plan.

5. The amount of disability or retirement benefits under the United States Social Security Act, The Canada Pension Plan, or the Quebec Pension Plan, or any similar plan or act, as follows:

   a. disability benefits for which:

      i. you are eligible; and
      ii. your spouse, child or children are eligible because of your disability; or

   b. retirement benefits received by:

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

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

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

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

1. have not been awarded; and

2. have not been denied; or

3. have been denied and the denial is being appealed.

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

1. apply for benefits under item 5.a; and

2. request and sign our Agreement Concerning Benefits.

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

1. of the amount awarded; or

2. that benefits have been denied and the denial is not being appealed.

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

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

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

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

When do these benefits cease?
Disability benefits will cease on the earliest of:

1. the date you are no longer disabled;

2. the date you die;

3. the end of the maximum benefit period;

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

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

RECURRENT DISABILITY

What happens if you try to return to work and become disabled again?
"Recurrent Disability" is a disability which is related to a prior disability for which you received a monthly benefit.

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

1. return to your regular occupation on a full-time basis for less than six months; and

2. perform all the material duties of your occupation.

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

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

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

SURVIVOR BENEFIT

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

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

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

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

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

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

GENERAL EXCLUSIONS

What disabilities aren't covered?
We will not cover any disability due to:

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

COST OF LIVING ADJUSTMENT

What are the eligibility requirements for cost of living adjustments?
You will be eligible for cost of living adjustments if you:

1. are receiving benefits on July 1st; and
2. have been disabled for one complete calendar year.

You will be eligible for additional cost of living adjustments on each subsequent July 1st if you are continuously receiving benefits under this plan. But no more than 10 adjustments may be made during your benefit period.

By what amount is your benefit adjusted?
Your net monthly benefit will be increased by the lesser of:

1. 1/2 of the annual percentage increase in the Consumer Price Index for the prior calendar year; or
2. 6%.

Each adjustment will be added to your net monthly benefit and will be paid monthly.

Are the increases subject to the maximum monthly benefit?
No, cost of living adjustment increases are not subject to the maximum monthly benefit.

What is the net monthly benefit?
The net monthly benefit means the amount determined by reducing your amount of insurance by other income benefits and any reductions for earnings. The net monthly benefit will be determined each month. For the purpose of calculating adjustments, the net monthly benefit will include any prior years' cost of living adjustments.

What is the Consumer Price Index?
The Consumer Price Index (CPI-W) is published by the U. S. Department of Labor. It measures the change in the cost of a typical urban wage earner's or clerical worker's purchases of certain goods and services. The change in cost is expressed as a percentage of the cost of these same goods and services in some base period.

We reserve the right to use some other similar measurement if the U. S. Department of Labor changes or stops publishing the CPI-W.

TERMINATION

When does your insurance terminate?
You will cease to be insured on the earliest of the following dates:

1. the date the policy terminates;
2. the date you are no longer in an eligible class;
3. the date your class is no longer included for insurance;
4. the later of:
   a. the end of the month for which you made any required employee contribution; or
   b. the date employment terminates.

   Cessation of active employment will be deemed termination of employment, except:
   a. if you are disabled your insurance will be continued during:
      i. the elimination period; and
      ii. while benefits are being paid.
   b. your employer may continue your insurance by paying the required premium, subject to the following:
      i. Insurance may be continued for the time shown in the plan outline if you are:
         a) temporarily laid off; or
         b) given leave of absence.
      ii. The employer must act so as not to discriminate unfairly among employees in similar situations.

CONVERSION PRIVILEGE

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

Who may not convert?
The conversion privilege is not available to you if:

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

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

Is the conversion coverage the same as that provided under this plan?
The Company governs the form of coverage, the benefits and the amounts. The benefits and amounts may differ from those under this plan.

SOME GENERAL INFORMATION TO KNOW

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

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

When does proof of claim have to be given?
You must give us proof of claim no later than 90 days after the end of the elimination period.

If it is not possible for you to give proof within these time limits, it must be given as soon as reasonably possible. But you may not give proof later than one year after the time it is otherwise required.

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

The proof must cover:

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

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

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

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

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

How can statements made in any application for this insurance be used?
In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim unless a copy of your statements has been given to you.

Can legal proceedings be started at any time?
No, you or your authorized representative cannot start any legal action:

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

What happens if facts are misstated?
If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid.

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

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

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

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

Name of Plan:
Champlain College, Inc. Plan

Name and Address of Employer:
Champlain College, Inc.

163 South Willard Street
P.O. Box 670
Burlington, VT 05402

Plan Identification Number:
a. Employer IRS Identification No.: 03-0220266
b. Plan #: 000504

Type of Welfare Plan:
Disability

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

ERISA Plan Year Ends: December 31

Plan Administrator, Name, Address and Telephone No.:
Champlain College, Inc.
163 South Willard Street
P.O. Box 670
Burlington, VT 05402

(802) 860-2700

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

Agent for Service of Legal Process on the Plan:
Same as above

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

Funding and Contributions:
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as the "insurance company") under policy number 342361. Contributions to the Plan are made as stated under **"Contributions"** in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST A POLICY CHANGE

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

YOUR RIGHTS IN THE EVENT OF PLAN TERMINATION

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

THE PLAN MAY TERMINATE

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

HOW TO FILE A CLAIM

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

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

CLAIMS PROCEDURES

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

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

1. state the specific reason(s) for determination;

2. reference the specific Plan provision(s) on which the determination is based;

3. describe additional material or information necessary to complete the claim and why such information is necessary;

4. describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from the insurance company on appeal; and

5. disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

APPEAL PROCEDURES

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

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

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

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

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

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

1. the specific reason(s) for determination;

2. a reference to the specific Plan provision(s) on which the determination is based;

3. a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

4. a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

5. the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

6. the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

OTHER RIGHTS

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

DISCRETIONARY ACTS

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

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