Voluntary Long-Term Disability Insurance

Employee Benefit Booklet

Administered by

MEDICAL LIFE INSURANCE COMPANY
Cleveland, Ohio

Town of Norton

Group Number: SA04630

CLASS I

MEDICAL LIFE INSURANCE COMPANY
(herein called We, Us, Our)
20445 Emerald Parkway Suite 400 • Cleveland, Ohio
1-800-692-1400

CERTIFICATE

We agree to pay benefits subject to the provisions, definitions, limitations and conditions of the group Master Policy (herein called the Policy). The Policy, Group Policy Series ML2200, is a contract issued by Medical Life Insurance Company to the Financial Services Trust (herein called the Trust).

This is your certificate of coverage. It is not valid unless accompanied by a copy of your signed Enrollment Form which, if satisfactory Evidence of Insurability is required, has been approved by Us. This certificate replaces any group certificate previously issued under the Policy. It is not a contract or a part of one. Your benefits are described in plain English, but a few terms and provisions are written as required by insurance law.

PLEASE READ CAREFULLY

If you have any questions, please contact the Benefits Administrator at your place of employment or write to Us. We will assist you in any way we can to help you understand your benefits.

President

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Schedule of Benefits

Class I All eligible employees

Amounts of Insurance

- Monthly Benefit: The amount you elected as shown on your enrollment form times 4.33, less Other Income benefits, not to exceed the Maximum Monthly Benefit of $5,000
- Minimum Monthly Benefit: $100

Maximum Benefit Period:

AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD FOR ACCIDENT	MAXIMUM BENEFIT PERIOD FOR SICKNESS
Less than Age 60	5 years	2 years
60	60 months	2 years
61	48 months	2 years
62	42 months	2 years
63	36 months	2 years
64	30 months	2 years
65	24 months	2 years
66	21 months	21 months
67	18 months	18 months
68	15 months	15 months
69 an over	12 months	12 months

Elimination Period: 90 days

Waiting Period:

- If you were hired on or before the policy effective date: none
- If you were hired after the policy effective date: first of the month following date of hire.

Contributions

You are required to contribute to the cost of your insurance.

Enrollment

Any certificate provision regarding late enrollees is replaced by the following provision:

An Employee may enroll or request a change to current voluntary benefits only during any Open Enrollment period.

Open Enrollment – Once each year, a time period to be determined by the Participating Employer will be designated as Open Enrollment. Eligible Employees may enroll in the Plan, apply for additional coverage, or request changes to their current Voluntary Benefit program(s) only during Open Enrollment. Employees hired after an Open Enrollment period may enroll within 31 days following their eligibility date; if a new Employee does not elect Voluntary coverage within that time period, he must wait for the next Open Enrollment to enroll.

Definitions

For the purpose of this coverage:

Active Employment means you must be working:

1. for the Employer on a permanent full-time basis and paid regular earnings;
2. at least the minimum number of hours shown in the Employer's Application for Group Voluntary Benefits; and either:
   a. at the Employer's usual place of business; or
   b. at a location to which the Employer's business requires you to travel.

Application is the document showing the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the policyholder.

Application/Change Form is the document showing the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the Participating Employer.

Basic Monthly Earnings or **Pre-Disability Income** means your monthly rate of earnings from the Employer in effect immediately prior to the date Disability begins. It does not include bonuses, overtime pay, and extra compensation other than commissions. Commissions will be averaged over the 12 month period prior to the date Disability begins.

Certificate means this benefit booklet prepared by us including all amendments, riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which you are entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

Disability Benefit, 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 defined in this Policy.)

Eligibility Date means the date you become eligible for insurance under the Policy. Classes are shown in the Employer's Application for Group Voluntary Benefits.

Elimination Period means a period of consecutive days of Disability for which no benefit is payable. The Elimination Period is shown on the Schedule of Benefits and begins on the first day of Disability.

Note: If your Elimination Period is 90 days and you return to work for any 7 or less days during the Elimination Period and cannot continue, We will count only those days you are Disabled to satisfy the Elimination Period. If your Elimination Period is 180 days and you return to work for any 14 or less days during the Elimination Period and cannot continue, We will count only those days you are Disabled to satisfy the Elimination Period.

Employee means a person in full-time active permanent employment with the Employer.

Employer or **Participating Employer** means a corporation, partnership or proprietorship which participates under the Policy. It includes any subsidiary or affiliated company named in the Employer's Application for Group Voluntary Benefits

Evidence of Insurability means a statement or proof of your medical history upon which acceptance for insurance will be determined by Us.

Home Office means Medical Life Insurance Company, 20445 Emerald Parkway Suite 400, Cleveland, Ohio 44135.

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.

Exception: Any disability which begins more than 60 days after an Injury will be considered a Sickness for the purpose of determining benefits under the Policy.

Male Pronoun whenever used includes the female.

Material And Substantial Duties means duties that:

1. are normally required for the performance of your Regular Occupation; and
2. cannot be reasonably omitted or modified, except that if you are required to work on an average in excess of 40 hours per week, We will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Monthly Benefit means the amount We will pay you when you are Disabled.

Own Occupation See Total Disability or Totally Disabled definition.

Physician means a person who:

1. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. is legally qualified as a medical practitioner operating within the scope of his license; and
3. is not your spouse, daughter, son, father, mother, sister or brother.

Pre-Disability Earnings - See Basic Monthly Earnings definition.

Regular Occupation means the occupation you are routinely performing when disability begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific Employer or at a specific location.

Retirement Benefit, 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 401(k), profit-sharing plan, informal salary continuation plan, thrift plan, individual retirement account (IRA), tax sheltered annuity (TSA), stock ownership plan, or a non-qualified plan of deferred compensation.

Employer's Retirement Plan is deemed to include any Retirement Plan:

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

Sickness means illness, disease, pregnancy or complications of pregnancy. The Sickness must begin while you are insured under the Policy.

Total Disability or **Totally Disabled** means during the Elimination Period and the next 24 months of disability you are:

1. unable to perform the Material And Substantial Duties of your Regular Occupation because of a disability:
   a. caused by Sickness or Injury;
   b. that started while you are insured under the Policy; and
2. after 24 months of benefits have been paid, you will continue to receive payment only if you are unable to perform with reasonable continuity all of the Material And Substantial Duties of your Regular Occupation or any other occupation for which you are or become reasonably fitted by training, education, experience, age and physical and mental capacity.

With respect to Insureds employed as pilots, co-pilots and crew of aircraft: "Total Disability" or "Totally Disabled" means because of Injury or Sickness you cannot perform the Material And Substantial Duties of any gainful occupation for which you are or become reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute Total Disability.

Waiting Period as shown in the Schedule of Benefits means the continuous length of time you must serve in an eligible class to reach your Eligibility Date. Credit will be given for any portion of the Waiting Period satisfied prior to an approved family or medical leave of absence.

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 through your employer on a form satisfactory to Us. Your insurance will start on the latest of these dates:

1. the date you enroll if you do so on or before the 31st day after your Eligibility Date, or
2. the date We give its approval, if you
   a. makes written application for insurance more than 31 days after his Eligibility Date; or
   b. terminated his insurance while continuing to be eligible.

   In the case of a. and b. above, you must submit an application and Evidence of Insurability to Us for approval. This will be at your expense.
3. Delayed Effective Date for Insurance - No initial, increased or additional insurance will apply to you if you are not in Active Employment because of a disability on the date such insurance otherwise would become effective. Such insurance will start for you on the day you return to active employment.

4. If you enter another eligible class, you will not be eligible for any additional benefits until you have completed a 30-day Waiting Period, and have been in active employment one full day in the new class.

Benefits

Progressive Partial Disability Benefit

We will pay a Progressive Partial Disability Benefit for a disability which is caused by an Injury or Sickness once you have met your Elimination Period. The Elimination Period can be a combination of total and partial disability, or all total, or all partial disability. You do not have to be totally disabled prior to receiving a Progressive Partial Disability Benefit.

To receive a Progressive Partial Disability Benefit, you must meet your Elimination Period and:

1. be able to perform one or more, but not all, of the Material And Substantial Duties of your Regular Occupation or any other occupation on a full-time or part-time basis; or
2. be able to perform all of the Material And Substantial Duties of your Regular Occupation or any other occupation on a part-time basis.

To qualify for a Progressive Partial Disability Benefit you must be earning less than 80% of your Pre-disability Income at the time partial disability employment begins.

You must supply proof that you are partially disabled from a Sickness or Injury and be under the regular care of a Physician.

To figure the amount of Progressive Partial Monthly Benefit:

1. Take the amount of monthly benefit elected.

2. Take the lesser of:
   a. the amount determined in step 1. above; or
   b. 100% of your Pre-disability Income less other income benefits, shown in the Other Income Benefit Section; or
   c. the Maximum Monthly Benefit shown in the Schedule of Benefits.

The Progressive Partial Disability Benefit will never be less than the Minimum Monthly Benefit shown on the Schedule of Benefits.

Proof of Disability

When Do Disability Benefits Become Payable?

When We receive proof that you are disabled due to Sickness or Injury and require the regular attendance of a Physician, We will pay you a Monthly Benefit after the end of the Elimination Period.

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 a benefit greater than your amount of insurance or any longer than the maximum benefit period shown in the Schedule of Benefits.

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 amount of monthly benefit elected.

2. Take the lesser of:
   a. the amount figured in step 1. above; or
   b. the Maximum Monthly Benefit shown in the Schedule of Benefits; and then
3. Deduct other income benefits, shown in the next section from this amount.

This is the total disability benefit which you may receive.

The Monthly Benefit will never be less than the Minimum Monthly Benefit shown in the Schedule of Benefits.

Other Income Benefits

Other income benefits mean those benefits shown below:

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 of the Employer;
   b. any governmental retirement system as a result of your job with the Employer.
4. The amount of benefits you receive under the Employer's Retirement Plan as follows:
   a. any Disability Benefits;
   b. any Retirement Benefits.

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 or unreduced Retirement Benefits for which:
      i. you are eligible; and
      ii. your spouse, child or children are eligible because of your disability; or
      iii. your spouse, child or children are eligible because of your eligibility for unreduced Retirement Benefits; or
   b. reduced Retirement Benefits received by:
      i. you; and
      ii. your spouse, child or children because of your receipt of the reduced Retirement Benefits.
6. The amount of any earnings you earn or receive from any form of employment.
7. The amount of earnings you receive from any sick leave or continuation plan paid by the Employer.

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

What Happens if You Receive Increases in These Other Income Benefits?

After the first deduction for each of the other income benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these other income benefits. This provision does not apply to increases received from any form of employment.

What if You Receive a Lump Sum Payment?

Other income benefits which are paid in a lump sum will be prorated 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. In each case, the amount to be prorated will be calculated by an actuary based on a morbidity table, with interest, or a mortality table, with interest, depending on the source of the lump sum.

When Does the Disability Monthly Benefit Cease?

The Monthly Benefit will cease on the earliest of

1. the date you are no longer disabled; or
2. the date you die; or
3. the end of the maximum benefit period; or
4. the date your current earnings exceed 85% of your Pre-disability Earnings.

   Note: Because your current earnings may fluctuate, We may average earnings over 3 consecutive months rather than immediately terminating your benefit once 85% of Pre-disability Earnings has been reached.

Benefit Period Extension

The maximum benefit period is shown in the Schedule of Benefits. However, benefits will be extended beyond the end of the maximum benefit period if you are disabled and have attained the age specified in the benefit duration and have not received twelve Monthly Benefit payments. In this event, the benefit period will be extended during the continuance of Disability until twelve monthly payments have been paid.

Recurrent Disability

“Recurrent disability” means a disability which is related or due to the same cause(s) as a prior disability for which a Monthly Benefit was payable.

A recurrent disability will be treated as part of the prior disability if, after receiving disability benefits under this Policy, 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.

To qualify for a recurrent disability benefit, you must experience more than a 20% loss of Pre-disability Earnings.

Benefit payments will be subject to the terms of the Policy 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.

If you become eligible for coverage under any other group long term disability policy, this recurrent disability section will cease to apply to you.

Waiver of Premium

While you are receiving benefits, premiums do not have to be paid. However, if coverage is to be continued, premium payments must be resumed following a period during which they had been waived.

Three Month Survivor Benefit

We will pay a lump sum benefit to the 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 lump sum benefit will be an amount equal to three times your Last Monthly Benefit.

“Eligible survivor” means your spouse, if living, otherwise your children under age 23.

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

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

“Last Monthly Benefit” means the Monthly Benefit paid to you immediately prior to your death but not including any reduction for earnings.

If there are no eligible survivors, payment will be made to your estate.

Mental Illness and/or Substance Abuse Limitation

Benefits for disability due to Mental Illness and Substance Abuse will not exceed 24 months of Monthly Benefit payments unless you meet one of these situations:

1. You are in a Hospital or Institution at the end of the 24 month period. The Monthly Benefit will be paid during the confinement.

   If you are still disabled when you are discharged, the Monthly Benefit will be paid for a recoveryperiod up to 90 days.

   If you become reconfined during the recovery period for at least 14 days in a row, benefits will be paid for the confinement and another recovery period up to 90 more days.

2. You continue to be disabled and become confined:

   a. after the 24 month period; and

   b. for at least 14 days in a row.

   The Monthly Benefit will be payable during the confinement.

   The Monthly Benefit will not be payable beyond the maximum benefit period.

“Hospital” or “Institution” means a facility licensed to provide care and treatment for the condition causing your disability.

“Mental Illness” means psychiatric, nervous or emotional diseases or disorders of any type.

“Substance Abuse” means a pattern of pathological use of alcohol or other psychoactive drugs resulting in: impairment of social and or occupational functioning; debilitating physical condition; inability to abstain from or reduce consumption of the substance; or the need for daily substance use for adequate functioning.

General Exclusions

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;

4. your commission of or your attempt to commit a felony or any type of assault or battery.

Riot shall include all forms of public violence, disorder or disturbance of the public peace, by three or more persons assembled together, whether or not acting with common intent and whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder.

Pre-existing Condition Exclusion

We will not cover any disability:

1. which is contributed to, caused by, or results from a pre-existing condition; and
2. which begins in the first 24 months after your effective date, unless you received no treatment of the condition for 6 consecutive months after your effective date.

“Treatment” means consultation, care or services provided by a Physician including diagnostic measures and taking prescribed drugs and medicines.

“Pre-existing Condition” means a Sickness or Injury for which you received treatment within 12 months prior to your effective date.

Benefit amounts selected at initial enrollment, as well as increases elected during subsequent annual enrollment periods, will be subject to this Pre-existing Condition Exclusion provision.

Continuity of Coverage Upon Transfer of Insurance Carriers

In order to prevent loss of coverage for an Employee because of a transfer of insurance carriers, we will provide coverage for certain employees as follows:

Failure to be in Active Employment Due to Injury or Sickness

We will cover you, subject to premium payments, if you:

1. were insured with the prior carrier at the time of transfer; and
2. are not in active employment due to Injury or Sickness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

Disability due to a Pre-existing Condition

Benefits may be payable for a total disability due to a pre-existing condition if you:

1. were insured by the prior carrier at the time of transfer; and
2. were in active employment and insured under the policy on its effective date.

The benefits will be determined as follows:

1. We will apply this policy's pre-existing condition exclusion. If you qualify for benefits, you will be paid according to this policy's benefit schedule.
2. If you cannot satisfy this policy's pre-existing condition exclusion, the prior carrier s pre-existing condition exclusion will be applied.
    a. If you satisfy the prior carrier's pre-existing condition exclusion, giving consideration towards continuous time insured under both policies, you will be paid according to the prior carrier's benefit schedule.
    b. If you cannot satisfy the pre-existing condition exclusion of this policy or that or the prior carrier, no benefit will be paid.

Termination Provisions

When Does Your Insurance Terminate?

You will cease to be insured at 12:00 midnight on the earliest of the following dates:

1. the date the Policy terminates but without prejudice to any claim originating prior to the time of termination;
2. the date your Employer's participation terminates;
3. the date you are no longer in an eligible class;
4. the date your class is no longer included for insurance;
5. the last day for which you made any required employee contribution;
6. the date employment terminates. Cessation of Active Employment will be deemed termination of employment, except:
   a. the insurance will be continued if you are absent due to Total Disability during:
      i. the Elimination Period; and
      ii. the period during which premium is being waived.
   b. your Employer may choose to continue your insurance by paying the required premiums, subject to the following:
      i. your insurance may be continued during an approved family or medical leave of absence, but not beyond the end of the approved leave of absence period; or
      ii. insurance may be continued if you are temporarily laid off or given any other leave of absence, but not beyond the end of the month following the month the

layoff or leave of absence begins; and

iii. the Employer must act so as not to discriminate unfairly among Employees in similar situations.

7. the date you cease active work due to a labor dispute, including any strike, work slowdown or lockout.

We reserve the right to terminate all classes if any class(es) ceases to be covered.

General Policy Provisions

How Can Statements Made in Any Application for This Insurance be Used?

In the absence of fraud, all statements made in any application are considered representations and not warranties (absolute guarantees). No representation by:

1. the policyholder in applying for the Policy will make it void unless the representation is contained in the Application; or
2. the participating employer in applying for coverage under this Policy will make it void unless the representation is contained in the Application for Group Voluntary Benefits; or
3. any employee in applying for insurance under this policy will be used to reduce or deny a claim unless a copy of the application for insurance is or has been given to the employee.

What Happens if Facts are Misstated?

If relevant facts about you are 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 under this policy.

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, We must be notified as soon as it is reasonably possible to do so.

When we receive your written notice of claim, we will send you our claim forms. If the forms are not received within 15 days after written notice of claim is sent, you may send us 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 to give proof within these time limits, it must be given as soon as reasonably possible. Except in the absence of legal capacity, proof of claim may not be given later than one year after the time proof is otherwise required.

You must give us proof of continued disability and regular attendance of a Physician within 30 days of the request for the proof. The proof must cover:

1. the date disability started:
2. the cause of disability; and
3. the degree of disability.

What Are Our Examination Rights?

We, at our own expense, will have the right and opportunity to have you examined by a Physician of our choice. This right may be used as often as reasonably required.

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.

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. We will pay any balance remaining unpaid upon the termination of the period of liability immediately upon receipt of due written proof.

To Whom are Claims Paid?

All benefits are payable to you. But if a benefit is payable to your estate, 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 Happens if Your Claim is Overpaid?

If LTD benefits have been overpaid on your claim, you will be required to reimburse Medical Life Insurance Company within 60 days, or Medical Life Insurance Company has the right to reduce future benefits until such reimbursement is received. Medical Life Insurance Company also has the right to recover such overpayments from your estate.

Does This Coverage Affect Workers' or Workmen's Compensation?

Coverage under the Policy is not in lieu of, and does not affect, any requirement for coverage by Workers' or Workmen's Compensation Insurance.

What Authority Does the Company have in Making a Benefits Determination?

In making any determination regarding the benefits under the policy, we shall have the discretionary authority to determine an individual's eligibility for benefits and to interpret the terms of the policy.

*ERISA Information Statement

Federal Law Requires We Include This Notice In Your Booklet

The benefits described in your certificate and this ERISA Information Statement (collectively the "Summary Plan Description" a/k/a the SPD) are insured by a Policy issued by Medical Life Insurance Company. This SPD describes the provisions of the Plan in effect as of the Effective Date of the Policy. It is not the intention of the SPD to cover all situations that may arise, but to provide you with a general understanding of your benefits. In the case of any item not covered by the SPD, or in the event of any conflict between the SPD and the Policy, the Plan will always control. You should not rely on any oral explanation, description, or interpretation of the Plan because the written terms of the Plan will govern. Your right to any benefit depends on the actual facts and terms and conditions of the particular Plan; no rights accrue by reason of or arising out of any statement shown in or omitted from, this SPD.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries.

***This ERISA addendum only applies if the Policy is part of or is an ERISA Plan.**

1/1/02

The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy must also be approved in writing by an officer of Medical Life Insurance Company (the "Insurer") and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. The Plan's life benefits are provided pursuant to an insurance policy issued to the Company.

The Insurer's services shall be limited to, and the Plan Administrator has the full discretionary and final authority to:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and Dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a).

The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits.

CLAIMS PROCEDURE

*Disability Insurance Plans

*(Applies to the Waiver of Premium based on disability in Life Certificates).

When you or your Beneficiary are eligible to receive benefits, you or your Beneficiary, or your authorized representative (collectively, "you") must notify the Plan Administrator by submitting the proper form. You may do this by sending notice of your claim to the Plan Administrator who has been appointed to assist Medical Life in the claims processing for this Plan or by contacting Medical Life directly at:

Claims Department
Medical Life Insurance Company
1220 Huron Road
Cleveland, OH 44115
1-800-782-8533

Medical Life will give you a written response to your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, Medical Life notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision shall be tolled from the date on which we send you notice of the extension until the date we receive your response to our request. This period will be no longer than 45 days after we have requested the information. At that time we will decide your claim based on the information we have at that time.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed;
- the steps that you have to follow to have the claim reviewed;
- a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal; and

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request; and
- if denial is based on medical judgement, either (i) an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

If the claim has been denied, in whole or in part, you can appeal the denial to us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a) request a review upon written application within 180 days of the claim denial;

b) request, free of charge, copies of all documents, records and other information relevant to your claim; and

c) submit written comments, documents, records and other information relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Medical Life will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, Medical Life notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision.

If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for your decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the Plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

Life Insurance Plans

A decision will be made by Medical Life no more than 90 days after receipt of due proof of loss, except in special circumstances (such as the need to obtain further information), but in no case more than 180 days after the due proof of loss is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

If the claim is denied, in whole or in part, you will receive a written notice giving the following:

- the reason for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other information, if any, may be needed to process the claim and why it is needed; and
- the steps that you have to follow to have the claim reviewed.

Any denied claim may appealed to Medical Life for a full and fair review. You may:

a) request a review upon written application within 60 days of receipt of claim denial;

b) review pertinent documents; and

c) submit issues and comments in writing.

A decision will be made by Medical Life no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to obtain additional evidence), but in no case more than 120 days after the request for review is received. The written decision will include specific reasons for the decision and specific references to the Plan provisions on which the decision is based.

C. ERISA NOTICE OF YOUR RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 to furnish each participant with a copy of this summary annual report.

In addition to creating rights for the 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 employers, your union, or any other persons, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 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 which 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 federal court. The court will decide who should pay costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, United States Department of Labor, 200 Constitution Avenue, NW Washington DC 20210.

D. PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute a contract between the Company and any participant or to be consideration or an inducement for the employment of any participant or employee. Nothing contained in this Plan shall be deemed to give any participant or employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or employee at any time regardless of the effect which such discharge shall have upon him or her as a participant of this Plan.