

GROUP SHORT TERM DISABILITY

CERTIFICATE OF COVERAGE

for

ISLAMIC SOCIETY SALAM SC

Policy Number: G/GA363182NM

Effective Date: January 1, 2011

STATE MANDATED DISABILITY REQUIREMENTS

The following states legislatively mandate that certain employers provide state disability benefits for employees working in the state:

California

Hawaii

New Jersey

New York

Rhode Island

Puerto Rico

The disability coverage available under this plan is not intended to replace any state mandated disability coverage. The disability benefits provided in this Certificate of Coverage will be reduced by any benefits received under a state mandated disability plan.

United HealthCare Insurance Company

450 Columbus Boulevard

Hartford, Connecticut

(Home Office)

Policyholder: ISLAMIC SOCIETY SALAM SC

Effective Date: January 1, 2011

Policy Number: G/GA363182NM - STD

Covered Person: As on file with the Administrator

Certificate Number: As on file with the Administrator

Certificate Effective Date: As on file with the Administrator

We, United HealthCare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at the Home Office of United HealthCare Insurance Company as of the Effective Date shown above.



Secretary



President

**Group Working Returns Short Term
Disability Insurance Policy
Non-Participating**

**Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343**

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SCHEDULE OF BENEFITS

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

Covered Person Insurance: ALL Eligible Employees

All full-time Employees working at least 30 hours per week.

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date, January 1, 2011
2. The first day of the month following the date the Covered Person completes 1 month of continuous employment with the Policyholder.

Cost of Insurance: The Covered Person may be required to contribute to the cost of his insurance.

Short Term Disability Benefit:

Benefit Percent: 66.67% of the Covered Person's Pre-Disability Weekly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings.

Pre-Disability Weekly Earnings Definition:

The average weekly earnings received from the Covered Person's Employer for the three-month period ending just prior to the date of Disability. Pre-Disability Weekly Earnings includes commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.

Maximum Weekly Benefit: \$500

Minimum Weekly Benefit: \$25

Elimination Period:

For Disability due to Injury: 0 days
For Disability due to Sickness: 7 days

Maximum Benefit Period:

26 Weeks of benefits
Premium contributions must continue while the Covered Person is receiving Short Term Disability payments.

STD Benefits are issued on a non-occupational basis.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

For Employees of school districts whose teachers and other personnel have work schedules dependent upon the school calendar, the Covered Person will be considered Actively at Work during a break in the school calendar if he was Actively at Work immediately prior to the break in the school calendar.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of a Policyholder will be considered an Employee unless he meets the above conditions.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's Spouse, children, parents, parents-in-law, or siblings.

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

GENERAL DEFINITIONS

We, Our and Us: United HealthCare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Discretionary Authority: When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms and provisions of the Policy. This provision applies, however, only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

Fraud: We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Payment of Premiums: No insurance provided by the Policy will be in effect until the first premium for such insurance is paid. For insurance to remain in effect, each subsequent premium must be paid on or before its due date. The Policyholder is responsible for paying all premiums as they become due. Premiums are payable on or before their due dates at Our Home Office. A Grace Period of 31 days from the Premium Due Date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will remain in effect provided the premium is paid before the end of the Grace Period. Written ten (10) days prior notice, insurance will terminate as of the end of the Grace Period. The Company will subtract the premium due for the Grace Period from any benefits payable. Payment of Premium for a period before it is due will not guarantee that the insurance will remain in effect for that period.

Premium Rate Change: We have the right to change premium rates as of any Premium Due Date but not more than once in any 24-month period. We will notify the Policyholder in writing at least 60 days prior to the change in rates.

The premium rate may change prior to this time however, for reasons that affect the insured risk, which include:

1. a change occurs in benefits;
2. a division, subsidiary, or affiliated company is added or deleted;
3. the number of Employees insured changes by 10% or more;
4. a new Law or a change in any existing Law is enacted which applies to the Policy.

CERTIFICATE GENERAL PROVISIONS

A change may take effect on an earlier date if both the Policyholder and We agree to it. Except in the case of fraud, premium adjustments, refunds or charges will be made for only the current Policy year.

Records: The Policyholder must furnish all information required by Us to:

1. compute premiums; and
2. maintain necessary administrative records.

Records of the Policyholder, which have a bearing on insurance, will be available for inspection by Us at any reasonable time.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
 - a. the date the Employee is eligible for insurance, regardless of when he applies; or
 - b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

Effective Date of Change in Amount of Insurance: If there is an increase in the amount of the Covered Person's insurance, the increase will take effect on:

1. the first day of the month on or next following the date of the increase, if the Covered Person is Actively at Work on the date of increase;
2. the date the Covered Person returns to Active Work if the Covered Person is not Actively at Work on the first day of the month on or next following the date of the increase;
3. the first day of the month on or next following the date of the increase, if the first day of the month is a non-working day and the Covered Person was Actively at Work on his last scheduled working day before the non-working day;
4. the date of the increase, if the Covered Person is on an approved layoff or leave of absence, for reasons other than a Sickness or Injury.

If evidence of insurability is required, the increase will take effect on the later of the dates indicated above or the date We approve his application.

A decrease in the amount of the Covered Person's insurance will take effect on the date of the decrease.

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his employer's policy on Family and Medical Leaves of Absence.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the last day of the month during which he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the last day of the month during which he ceases to be Actively at Work, unless active work ceases due to a temporary layoff or approved leave of absence. In such case, insurance will not continue beyond the end of the month following the month in which the layoff or leave began. For a leave of absence governed by federal or any applicable state Family and Medical Leave of Absence law, insurance will be continued in accordance with the Family and Medical Leave of Absence provision.
5. the date he is no longer Actively at Work due to a labor dispute, including but limited to strike, work slow down or lock out.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

The Covered Person is Disabled or has a Disability when We determine that:

1. he is not Actively at Work and is unable to perform some or all of the Material and Substantial Duties of his Regular Occupation due to his Sickness or Injury; and
2. he has a 20% or more loss in Pre-Disability Weekly Earnings due solely to the same Sickness or Injury; and
3. he is under the Regular Care of a Physician.

Material and Substantial Duties: duties that

1. are normally required for the performance of the Covered Person's Regular Occupation; and
2. cannot be reasonably omitted or modified.

Regular Occupation means: the occupation which the Covered Person is routinely performing when his Disability occurs. We will look at the Covered Person's 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.

Disability must begin while the Covered Person is insured under the Policy.

The loss of a professional or occupational license or certification, work permit, or visa does not, in itself, mean the Covered Person is Disabled. Additionally, economic factors, such as recession, job obsolescence, pay-cuts and job sharing will not be considered in determining whether the Covered Person meets the definition of Disability/Disabled.

We require the Covered Person to be under the Regular Care of a Physician for the Sickness or Injury causing his Disability in order to be eligible to receive payments from Us.

We may require the Covered Person to be examined by Physicians, other medical practitioners or vocational experts of Our choice. We will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require the Covered Person to be interviewed by an authorized representative of Ours. Refusal to be examined or interviewed may result in denial or termination of his claim.

Calculating the Weekly Payment:

The Covered Person's Weekly Payment will be determined as follows:

1. If the Covered Person is Disabled and not working, or working and earning less than 20% of his Pre-Disability Weekly Earnings, the Covered Person's Weekly Payment will be determined as follows:
 - a. Multiply his Pre-Disability Weekly Earnings by the Benefit Percent.
 - b. Compare the result in Step 1a with the Maximum Weekly Benefit.
 - c. The lesser of these two amounts is the Covered Person's weekly Gross Disability Payment.
 - d. Subtract from his weekly Gross Disability Payment any Other Income Benefit amounts that he receives or is eligible to receive. The result is the Covered Person's Weekly Payment.
2. If the Covered Person is Disabled and working earning between 20% and 80% of his Pre-Disability Weekly Earnings, the Covered Person's Weekly Payment will be determined as follows:
 - a. Multiply his Pre-Disability Weekly Earnings by the Benefit Percent.
 - b. From 100% of his Pre-Disability Weekly Earnings subtract any Other Income Benefits, and any income he earns or receives from any form of employment.
 - c. Compare the result in Steps 2a and 2b with the Maximum Weekly Benefit.
 - d. The lesser of the amounts from 2c is the Covered Person's Weekly Payment.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

After the Elimination Period, if the Covered Person is Disabled for only part of a week, We will send him 1/7th of his Weekly Payment for each day of Disability.

Gross Disability Payment means: the payment amount before We subtract Other Income Benefits and Disability Earnings.

Receipt of Disability Payments: The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each week for any period for which We are liable. If he is Disabled and working, proof of Disability Earnings will be required before benefits are paid.

Disability Earnings mean: the earnings, which the Covered Person receives while Disabled, and working.

Elimination Period means: the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability.

Hospital Confined or Hospital Confinement means: the Covered Person is admitted as an inpatient in a Hospital or Medical Facility for a period of at least 24 hours for the condition resulting in his Disability.

Disability During a Covered Layoff or Leave of Absence: If the Covered Person becomes Disabled while he is on a covered layoff or leave of absence, We will calculate his benefit using his Pre-Disability Weekly Earnings from his employer in effect just prior to the date his absence begins.

Other Income Benefits: We will subtract from the Covered Person's Gross Disability Payment the following Other Income Benefits:

1. any benefits and awards he receives or is eligible to receive under:
 - a. Workers' Compensation Law;
 - b. occupational disease Law; or
 - c. any other similar Act or Law.unless this insurance is issued on a non-occupational basis as shown in the Schedule of Benefits.
2. any Disability income benefits he receives or is eligible to receive under:
 - a. any compulsory benefit act or Law;
 - b. any other group insurance policy with the employer or with an association;
 - c. any other group insurance policy with another employer under which he becomes covered while he is Disabled under the Policy; or
 - d. any governmental retirement system as the result of his job with his employer.
3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, the Jones Act and any other similar plan or Act. Benefits include:
 - a. Disability benefits he is eligible to receive and any disability benefits his Spouse or his children receive or are eligible to receive as a result of his Disability.
 - b. retirement benefits he receives and any retirement benefits his Spouse or his children receive as a result of his receipt of retirement benefits.

If the Covered Person's Disability begins after his 70th birthday, and he was receiving Social Security retirement benefits before his Disability began, then We will not reduce Our payments to him by these retirement benefits.

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

4. any benefits he receives from his employer's sick leave or salary continuation plan.
5. any benefits from the employer's Retirement Plan he:

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

- a. receives as disability benefits;
- b. voluntarily chooses to receive as retirement benefits; or
- c. receives as retirement benefits once he reaches the greater of age 62 or normal retirement age, as defined in his employer's Retirement Plan.

Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to the Covered Person, We consider Employee and employer contributions to be distributed at the same time throughout the Covered Person's lifetime.

We will not reduce payments the Covered Person receives from Us for his contributions to the Employer's Retirement Plan, or for amounts he rolls over or transfer to an eligible Retirement Plan.

Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

Retirement benefits under a retirement plan are benefits that are paid based on the Covered Person's employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition.

6. any benefits for loss of time or lost wages he receives from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.
7. any amount he receives under any unemployment compensation Law, unless this insurance is issued on a non-occupational basis as shown in the Schedule of Benefits.
8. any amounts he receives from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension Plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a Retirement plan from another employer
12. Individual Retirement Accounts (IRA)
13. benefits from individual disability plans

Affect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We
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will pay the Covered Person the Minimum Weekly Benefit shown in the Schedule of Benefits. The Minimum Weekly Benefit, however, may be applied toward an outstanding overpayment.

Estimating Amounts of Other Income Benefits: We have the right to estimate the amount of benefits the Covered Person may be eligible to receive under the "Other Income Benefits" section. We can reduce Our payments to him by the estimated amount if:

1. he has not been awarded but has not been denied such benefits; or
2. he has been denied such benefits and the denial is being appealed; or
3. he is reapplying for such benefits.

We will NOT reduce Our payments to the Covered Person by the estimated amount if:

1. he applies or reapplies for the benefits and appeals his denial through all of the administrative levels We believe are necessary; or
2. he signs Our reimbursement agreement form stating that he promises to pay Us any overpayment caused by an award.

If We reduce Our payments to the Covered Person by an estimated amount:

1. We will adjust Our payment to him when he provides proof of the amount awarded; or
2. We will issue a lump sum refund of the estimated amount if he was denied benefits and has completed all appeals (or reapplications) We believe are necessary.

Continuity Of Insurance Upon Transfer Of Insurance Carriers: In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Employees as follows:

Employees who are not Actively at Work due to Sickness or Injury:

We will insure the Employee under the Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Employee will be limited to the lesser of the Weekly Payment under this Policy or the weekly payment the prior group insurance policy would have paid him, had that policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

Recurrent Disability: If the Covered Person's current Disability is related or due to the same causes(s) as his prior Disability for which We made a payment, We will treat his current Disability as part of his prior claim. He will not have to complete another Elimination Period if he returns to Active Work for his employer on a full time basis for 14 consecutive days or less. His Disability will be subject to the same terms of the Policy as his prior claim and will be treated as a continuation of that Disability.

Any Disability which occurs after 14 consecutive days from the date the Covered Person's prior claim ended will be treated as a new claim. His new claim will be subject to all of the provisions, including the Elimination Period.

If he becomes entitled to benefits under any other Group Short Term Disability policy, he will not be eligible for payments under the Policy.

Recurrent Disability means: a Disability that is:

1. caused by a worsening in the Covered Person's condition; and
2. due to the same or related cause(s) as his prior Disability for which We made a payment.

Rehabilitation Services: A rehabilitation program is available to assist the Covered Person in his return to work. Participation in this program is voluntary on his part and will be offered at Our discretion.

Our vocational rehabilitation specialists will review the Covered Person's file to determine if rehabilitation services might help him return to a Gainful Occupation. Once the review is completed, We may offer and pay for a return to work program. We will work with the Covered Person's Physician and other appropriate specialists to develop a plan that best suits the Covered Person's needs.

The return to work program may include, but is not limited to, the following services:

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

1. coordination with the Covered Person's Employer to assist him in his return to work;
2. evaluation of adaptive equipment to allow the Covered Person to work;
3. vocational evaluation to determine how his Disability may impact his employment options;
4. job placement services;
5. resume preparation;
6. job seeking skills training;
7. retraining for a new occupation; or
8. assistance with relocation that may be part of an approved return to work program.

We reserve the right to make the final decision concerning the Covered Person's eligibility to take part in a rehabilitation program and the amount of any services he will be provided.

Employee Outreach Services: We may provide Employee Outreach Services for a Covered Person who has a medical disability accompanied by psychosocial problems that may interfere with his recovery and return to work.

Employee Outreach Services will be provided at our discretion and may include, but are not limited to:

1. service provider referrals; and
2. identifying available community and state resources that may be helpful in the Covered Person's recovery and return to work.

Termination of Benefits: We will stop sending the Covered Person payments and his claim will end on the earliest of:

1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period;
3. the date he fails to provide proof of continuing Disability;
4. the date he is able to increase his Disability Earnings by increasing the number of hours he works or the number of duties he performs, but he chooses not to do so;
5. the date he refuses to be examined by a Physician, if such an exam is requested by Us;
6. the date he refuses to be interviewed by one of Our representatives;
7. the date he ceases to be under the Regular Care of a Physician;
8. the date he dies.

General Exclusions: We will not cover a Disability under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. intentionally self-inflicted Injuries;
3. active participation in a riot;
4. committing or attempting to commit a felony;
5. an Occupational Sickness or Injury if the Schedule of Benefits indicates that benefits are issued on a non-occupational basis. However, We will cover Disabilities due to an Occupational Sickness or Injury for partners or sole proprietors who cannot be covered by Workers' Compensation Law.

We will not make a payment for any period of time during which the Covered Person is incarcerated or under House Arrest. The Maximum Benefit Period will be reduced by the amount of time he is incarcerated or under House Arrest after completion of the Elimination Period.

Occupational Sickness or Injury means: an Injury arising out of, or in the course of, any work for wage or profit regardless of employer, or a Sickness covered, with respect to such work, by any Workers' Compensation Law, occupational disease law or similar law.

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House Arrest means: any restriction placed on the Covered Person's movement outside of his home by a court of competent jurisdiction. Compliance with such restriction is regularly monitored using electronic or other means.

Claim Information:

Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the Covered Person within 30 days after the date his Disability begins. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature and extent of the Disability.

The Covered Person must notify Us immediately when he returns to work in any capacity.

Filing a Claim: The Covered Person and his employer must fill out their own section of the claim form and then give it to the Covered Person's attending Physician. The Physician should fill out his section of the form and send it directly to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the Covered Person's Elimination Period ends. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include:

1. the date the Covered Person's Disability began;
2. appropriate documentation of the Disabling disorder;
3. the extent of the Covered Person's Disability, including restrictions and limitations preventing him from being Actively at Work and performing his Regular Occupation;
4. the appropriate documentation of the Covered Person's earnings;
5. the name and address of any Hospital or Medical Facility where the Covered Person received Treatment;
6. the name and address of all Physicians providing Regular Care or specialty care.

We may request that the Covered Person send proof of continuing Disability, satisfactory to Us, indicating that he is under the Regular Care of a Physician. This proof, provided at the Covered Person's expense, must be received within 30 days of a request by Us.

In some cases, the Covered Person will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of his proof of claim, or proof of continuing Disability. We will deny a Covered Person's claim or stop sending him payments if the appropriate information is not submitted.

Payment of Claim: Except as otherwise noted for specified additional benefits that may be included in the Policy, all benefits are payable to the Covered Person. If a benefit is payable to the Covered Person's estate, to a minor or to someone who is not competent to give a valid release, We have the right to pay up to \$1,000 to any of the Covered Person's relatives whom We consider entitled. Any amount We pay in good faith releases Us from further liability, but only for the amount paid.

Overpayment of Claim: We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's Spouse if living, otherwise children under the age of 21 or estate.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE FOR COVERED PERSON

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than six years after the date of loss.

WORKING RETURNS SHORT TERM DISABILITY INSURANCE OPTIONAL BENEFIT LUMP SUM SURVIVOR BENEFIT

When We receive proof that the Covered Person died, We will pay his Spouse, if living, otherwise, his children under age 21 a lump sum benefit equal to 3 weeks of the Covered Person's weekly Gross Disability Payment but not to exceed \$3,000.

The Lump Sum Survivor Benefit will be paid if, on the date of the Covered Person's death:

1. his Disability had continued for at least 15 consecutive days; and
2. he was receiving or was entitled to receive a Weekly Payment under the Policy.

If the Covered Person has no living Spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on his claim.

STATUTORY PROVISIONS

ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to:

United HealthCare Insurance Company
Administrative Offices
6300 Olson Memorial Highway
Golden Valley, MN 55427
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
Little Rock, Arkansas 77204
Telephone: 1-800-852-5494

MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota situated Employers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits
Contract Services
MN010-W115
6300 Olson Memorial Highway
Golden Valley, MN 55427

MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

Conformity with Montana Statutes: For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

Disability Pre-Existing Exclusion

Any applicable Pre-Existing exclusion will not be applied to any disability that begins more than 12 months after the Covered Person's Effective Date of insurance.

NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

Discretionary Authority

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Occupational Injury or Sickness Exclusion

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following:

An Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

NORTH DAKOTA

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

10 Day Right to Examine Certificate: There is a 10 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 10 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 10 day period will be deducted from the refund.

OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

Certificates delivered to residents of state of Oklahoma are subject to Oklahoma laws.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call United HealthCare Insurance Company's toll-free telephone number for information or to make a complaint at

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de United HealthCare Insurance Company's para informacion o para someter una queja al

800-554-5413

You may also write to United HealthCare Insurance Company at:

United HealthCare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343

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

800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX#(512) 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

800-554-5413

Usted tambien puede escribir a United HealthCare Insurance Company's:

United HealthCare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343

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

800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX#(512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ADJUNTAR ESTE AVISO A SU POLIZA:

Esto aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Incontestability

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).

STATEMENT OF EMPLOYEE ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to 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.

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. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 you the materials and pay you up to \$110 per day until you receive your 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 a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. 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 costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

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, contact the nearest Area Office of the Employee Benefits Security Administration, United States 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.

CLAIMS DENIAL FOR DISABILITY INSURANCE

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial; 2) reference to the provision(s) of the Plan on which the denial is based; 3) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to

provide all necessary information, and an explanation of why such material or information is necessary; and 4) an explanation of the claim review procedure. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR DISABILITY INSURANCE

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision will give specific reason(s) for the decision and references to the provision(s) of the Plan on which the decision is based. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review.

