PADI Worldwide Corp.

Your Group Long Term Care Insurance Plan

Policy No. 544252

Home and Community-Based Care

Underwritten by Unum Life Insurance Company of America

01-2019

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Policy.

Policy Number: 544252 COMPREHENSIVE LONG TERM CARE INSURANCE

Caution: If you completed an Application for Long Term Care Insurance which included evidence of insurability, the issuance of this long term care insurance certificate was based upon your responses to the questions on your application. A copy of your Application for Long Term Care Insurance was retained by you when you applied. If your answers are incorrect or untrue, UNUM may have the right to deny benefits or rescind your coverage. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact UNUM at this address: UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

Renewability: The Policy is renewable at the option of the Policyholder and UNUM. This means that your coverage under the plan may be changed or ended at the option of the Policyholder or UNUM. If your coverage is ended by the Policyholder or UNUM, you will have a guaranteed right to elect converted coverage.

THE POLICY FOR LONG TERM CARE INSURANCE IS INTENDED TO BE A FEDERALLY QUALIFIED LONG TERM CARE INSURANCE CONTRACT AND MAY QUALIFY YOU FOR FEDERAL AND STATE TAX BENEFITS.

THIS CERTIFICATE IS AN APPROVED LONG TERM CARE INSURANCE CERTIFICATE UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS CERTIFICATE WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1-800-434-0222.

- You are entitled to examine a copy of the Policy during regular office hours at the Policyholder's place of business.
- You have a 30 day right to examine this certificate.

  If, after examining this certificate, you are not satisfied for any reason, you may withdraw your enrollment in this plan by returning this certificate within 30 days of its delivery to you. The certificate, together with a written request for such withdrawal, must be sent to the Policyholder's Plan Administrator.

  Upon receipt, your insurance will be deemed void from its effective date and any premium contribution(s) paid will be returned.

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NOTICE TO BUYER: This certificate may not cover all of the costs associated with long term care incurred by you during the period of coverage. You are advised to review carefully all coverage limitations.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for people with Medicare, available from UNUM.

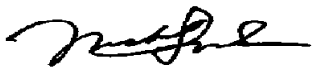
UNUM is not representing Medicare, the federal government or any state government.

Throughout this certificate:

"You" or "your" means an "insured" or "covered" **Active Employee** and "insured" or "covered" **Family Member**.

"UNUM" or "we" means UNUM Life Insurance Company of America, and

"Policyholder" means PADI Worldwide Corp. and its covered divisions, subsidiaries, and affiliated companies.



President

CALIFORNIA
CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-421-0344
(Customer Information Call Center)

-OR-

WRITING TO:
UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:
1-800-321-3889, option 2
(Compliance Center Complaint Line)

-OR-

WRITING TO:
Deborah J. Jewett, Manager, Customer Relations
UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR IDENTIFICATION NUMBER.

If the Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street - South Tower
Los Angeles, California 90013
Toll Free Instate Hotline Telephone Number: 1-800-927-4357
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. - 5:00 p.m.

This form is for contact information only, and it is not to be considered a condition for the Policy.

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SUMMARY OF BENEFITS

THIS PAGE SUMMARIZES ALL THE BENEFITS AVAILABLE FOR THE EMPLOYEES OF PADI WORLDWIDE CORP. REFER TO YOUR SCHEDULE OF BENEFITS FORM WHICH OUTLINES YOUR INDIVIDUAL BENEFIT SELECTION(S).

Elimination Period- 90 consecutive days. (See BENEFIT INFORMATION section for details.) **This applies to all employees of PADI Worldwide Corp..**

BASE COVERAGE

Monthly Benefit Amount

Nursing Facility	Residential Care Facility/ Residential Care Facility for the Elderly
$3,000 to $6,000 in $1,000 increments	70% of the Nursing Facility Monthly Benefit

Daily Benefit Amount

Home Care

50% of the $3,000 Nursing Facility Monthly Benefit= $50/Day
50% of the $4,000 Nursing Facility Monthly Benefit= $66.67/Day
50% of the $5,000 Nursing Facility Monthly Benefit= $83.33/Day
50% of the $6,000 Nursing Facility Monthly Benefit= $100/Day

Respite Care

Benefit payment is based on where care is received. See BENEFIT INFORMATION section for details. **This applies to all employees of PADI Worldwide Corp..**

ADDITIONAL COVERAGE OPTIONS

Monthly Benefit Amount *

Lifetime Maximum Amount ** (the maximum UNUM will pay you for all long term care benefits)

Plan A	Plan B	Plan C
3 Year Benefit Duration	**6 Year Benefit Duration**	**Lifetime Benefit Duration**
36 X the "Nursing Facility" amount.	72 X the "Nursing Facility" amount.	Unlimited

******Your Lifetime Maximum Amount will be adjusted to include any inflation option increases, if applicable.

Evidence of Insurability Limits

Evidence of insurability satisfactory to UNUM is required for:

- Monthly Benefit Maximum Amount(s) greater than $4,000; or
- an Unlimited Lifetime Maximum Amount.

If UNUM approves your evidence of insurability (i.e. Application for Long Term Care Insurance), the "PRE-EXISTING CONDITIONS EXCLUSION" will be waived for your entire amount(s) of insurance. If UNUM disapproves your evidence of insurability, you will be insured for the amount selected up to the amount that does not exceed the evidence of insurability limit(s). The "PRE-EXISTING CONDITIONS EXCLUSION" will apply.

CHANGES IN COVERAGE

Increases in Coverage

You have the option to elect to increase coverage from the benefits shown in the SUMMARY OF BENEFITS, no less frequently than on each anniversary date after the Policy is issued. Additional premium will be charged for any increases.

You can apply to increase coverage by filling out a new Benefit Elections Form and Application for Long Term Care Insurance. Increases in coverage will take effect at 12:01 a.m. on the first day of the month on or next following the month in which Unum approves your Application for Long Term Care Insurance. The premium rate to be paid for any increase in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the increase in coverage.

Decreases in Coverage:

You have the right, exercisable any time after the first year, to lower premium by reducing coverage from the benefit shown on the insured person's SCHEDULE OF BENEFITS, or to discontinue Home Care coverage.

You can apply to decrease coverage by filling out a new Benefit Elections Form. Decreases in coverage will take effect at 12:01 a.m. on the first day of the month on or next following the month in which Unum receives the Benefit Elections Form. The premium rate to be paid for any decrease in coverage is based on your age at your original issue age.

WHEN CHANGES IN COVERAGE WILL BE DELAYED FOR ACTIVE EMPLOYEES

Changes in your coverage will not begin if you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence on the date that the coverage would normally begin. Coverage will begin at 12:01 a.m. on the first day of the month after you return to work as an **Active Employee**.

DISCRETIONARY AUTHORITY

In making any benefits determination under the Policy, Unum will have the discretionary authority both to determine your eligibility for benefits and to construe the terms of the Policy.

ELIGIBILITY FOR BENEFITS

You are eligible for a Monthly Benefit after:

- you become **Disabled**; and
- a **Physician** has certified that you are unable to perform (without **Substantial Assistance** from another individual) two of six **Activities of Daily Living** (ADLs) for a period of at least 90 days, or that you require **Substantial Supervision** by another individual to protect you and others from threats to health or safety due to **Severe Cognitive Impairment**. You will be required to submit a **Physician** certification every 12 months.

The treatment and services you receive for your **Disability** must be provided pursuant to a plan of care developed by a **Licensed Health Care Practitioner**.

"**Activities of Daily Living**" **(ADLs)** are:

- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the act of getting into or out of the tub or shower.
- DRESSING - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- TOILETING - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- TRANSFERRING - the ability to move into and out of a bed, a chair, or wheelchair, or the ability to walk or move around inside or outside the home, regardless of the use of a cane, crutches, or braces.
- CONTINENCE - the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food in the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"**Disability**" **and** "**Disabled**" mean:

- you are unable to perform, without **Substantial Assistance** from another individual, at least two **Activities of Daily Living**; or
- you require **Substantial Supervision** by another individual to protect you from threats to health and safety due to **Severe Cognitive Impairment**.

"**Licensed Health Care Practitioner**" means any **Physician**, and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

"**Physician**" means a person, other than yourself, who is operating within the scope of his/her license, and is either:

- licensed to practice medicine and surgery and prescribe and administer drugs; or

- legally qualified as a medical practitioner and required to be recognized, under this plan for insurance purposes, according to the insurance laws of the governing jurisdiction.

Unum will consider a person to be a **Physician** only when the person is performing tasks that are within the limits of the person's medical license. Unum will not recognize the following as **Physicians** for claims that you make to us under the Policy:

- you, or
- your spouse, daughter, son, parent, sister, brother, grandparent or grandchild.

"**Severe Cognitive Impairment**" means a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:

- your short or long term memory;
- your orientation as to person, place and time; and
- your deductive or abstract reasoning.

Such deterioration or loss requires **Substantial Supervision** by another individual for the purpose of protecting you from harming yourself or others. The loss can result from a **Disability**, Alzheimer's disease, or similar forms of dementia.

"**Substantial Assistance**" means stand-by assistance by another person without which you would not be able to safely and completely perform the **ADL**.

"**Substantial Supervision**" means the presence of another individual for the purpose of protecting you from harming yourself or others.

"**Independent Licensed Health Care Practitioner Certification**"

You have the right to provide us with a certification of your **Disability** from a **Licensed Health Care Practitioner**. You also have the right to request that we coordinate an assessment of your condition by an independent **Licensed Health Care Practitioner** that is not an employee of our company, and whose compensation is not related in any manner to the outcome of the certification.

If a practitioner determines that you do not meet the definition of **Disabled** you have the right to request a second in person assessment by a **Licensed Health Care Practioner**. The requirement for a second assessment shall not be made available to you if the intitial assessment was performed by a practitioner who personally examined you.

If requested, these certification assessments will be performed promptly, shall be renewed every 12 months, and the costs associated with the assessment requests will be paid for by us and will not count against the lifetime maximum of your certificate. If a practitioner completes a personal examination, that practitioner will develop a written plan of care for you.

FACILITY BENEFITS

Once you become eligible for benefits, a **Nursing Facility**, **Residential Care Facility**, or **Residential Care Facility for the Elderly** monthly benefit will become payable after you have completed the **Facility Elimination Period**, and you are residing in a **Nursing Facility**, **Residential Care Facility**, or **Residential Care Facility for the Elderly** . The treatment and services you receive for your **Disability** must be provided pursuant to a plan of care developed by a **Licensed Health Care Practitioner**.

"**Facility Elimination Period**" means the number of consecutive days during which you must be eligible for benefits before benefits become payable. It must be satisfied while residing in a **Nursing Facility**, **Residential Care Facility**, or **Residential Care Facility for the Elderly**. The entire **Facility Elimination Period** must be satisfied only once in your lifetime.

Recurrent Disability

You will not have to complete a new **Facility Elimination Period** if you become **Disabled** again after the date we stopped making monthly benefit payments to you for your previous eligibility.

"**Nursing Facility**" means:

- an institution, or a distinctly separate part of a hospital, that is licensed or certified as a nursing home (if licensing or certification is required) or operates under the law as a nursing home to provide skilled, intermediate or custodial care and operates under state licensing laws and any other laws that apply; or
- any other institution that meets all of the following tests:
  - is operated as a health care facility under applicable state licensing laws and any other laws;
  - primarily provides nursing care under the orders of a **Physician**;
  - provides patient care under the supervision of a registered nurse or a licensed vocational nurse;
  - regularly provides room and board and continuous 24 hour a day nursing care of sick and injured persons;
  - maintains a daily medical record of each patient who must be under the care of a **Physician**;
  - is authorized to administer medication to patients on the order of a **Physician**; and
  - is not, other than incidentally:
    - a home for the mentally retarded, the mentally ill, the blind or the deaf, alcoholics or drug abusers, or
    - a hotel, a domiciliary care home or a residence; or
- a similar institution approved by Unum.

"**Residential Care Facility**" means:

- an institution that is licensed as a **Residential Care Facility** by the appropriate licensing agency and operates under state licensing laws and any other laws that apply; or
- a similar institution approved by Unum.

Note: These requirements are typically met by **Residential Care Facilities** that are either free-standing facilities or part of a life-care community. In general, they are not met by individual residences, boarding homes, or independent living units.

"**Residential Care Facility for the Elderly**" means a housing arrangement chosen voluntarily by persons 60 years of age or over, or their authorized representative, where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided, based upon the varying needs, as determined in order to be admitted and to remain in the facility. Persons under 60 years of age with compatible needs may be allowed to be admitted or retained in a **Residential Care Facility for the Elderly**.

Bed Reservation Benefit

If you are receiving a **Nursing Facility**, **Residential Care Facility**, or **Residential Care Facility for the Elderly** monthly benefit and your stay in the Facility is interrupted because you are hospitalized, we will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the Facility.

If your stay is interrupted because you are hospitalized while you are completing your **Facility Elimination Period**, such days will be used to help satisfy this period.

Bed Reservation days will be limited to 15 days per calendar year.

Amount of Facility Monthly Benefit

The amount of your Facility monthly benefit will be based on the Facility coverage options you chose from the SUMMARY OF BENEFITS. The amount of your Facility monthly benefit is shown on the SCHEDULE OF BENEFITS form attached to and made a part of this Certificate.

Unum will send you a lump sum payment to cover the period between the day you became eligible for monthly benefit payments and the day you were approved for these payments. Unum will then send you a payment each month for the number of days you were eligible to receive benefits during the prior month. Benefit payments will cease as provided in the provision "**WHEN MONTHLY BENEFIT PAYMENTS END**".

Facility Waiver of Premium

Once a **Nursing Facility**, **Residential Care Facility** or **Residential Care Facility for the Elderly** benefit becomes payable, there will be no more cost for your coverage as long as you are **Disabled** and residing in a **Nursing Facility**, **Residential Care Facility**, or **Residential Care Facility for the Elderly**. If benefits are no longer payable, you **must** resume premium payments to continue your coverage.

We will notify you of the amount of your next premium payment and the date it is due.

HOME CARE BENEFIT

Once you become eligible for benefits, a **Home Care**, monthly benefit will become payable after you have completed the **Home Care Elimination Period**; and you are receiving **Home Care Services** under a written **Plan of Care**

"**Home Care**" means services provided to you in your home by care providers who are NOT **Family Members**.

"**Home Care Elimination Period**" means the number of consecutive days during which you must be eligible for benefits before benefits become payable. The **Home Care Elimination Period** must be satisfied while you are receiving **Home Care Services**. Each calendar week that you receive at least one day of **Home Care Services** will be counted as seven days toward completing the **Home Care Elimination Period**. However, if you do not receive **Home Care Services** for at least one day within a calendar week, the **Home Care Elimination Period** will begin again. **Home Care Services** must be received in consecutive weeks to be counted toward completion of the **Home Care Elimination Period**. The entire **Home Care Elimination Period** must be satisfied only once in your lifetime.

Recurrent Disability

You will not have to complete a new **Home Care Elimination Period** if you become **Disabled** again after the date we stopped making monthly benefit payments to you for your previous eligibility.

"**Home Care Services**" mean services provided under a **Plan of Care** This does not include care or services provided by **Family Members**. **Home Care Services** include:

- **Adult Day Care** - medical or nonmedical care on a less than 24-hour basis, provided in an **Adult Day Care Facility** or a licensed facility outside your residence for persons in need of personal services, supervision, protection or assistance in sustaining daily needs, including bathing, dressing, toileting, transferring, eating and taking medications.
- **Adult Day Care Facility** - a facility that provides **Adult Day Care** and operates under state licensing laws and any other laws that apply.
- **Home Health Care** - skilled nursing or other professional services in your residence (i.e., where you live).
- **Homemaker Services** - assistance with activities necessary to or consistent with your ability to remain in your residence that is provided by a skilled or unskilled person (excluding **Family Members**) under a **Plan of Care**.
- **Hospice Services** - outpatient services that are designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a person who is experiencing the last phases of life due to the existence of a terminal disease and to provide supportive care to the primary caregiver and the family. Care may be provided by a skilled or unskilled person (excluding **Family Members**) under a **Plan of Care**.
- **Personal Care** - assistance with **Activities of Daily Living (ADLs)**, including the instrumental ADLs, provided by a skilled or unskilled person (excluding **Family Members**) under a **Plan of Care**. Instrumental ADLs include using the telephone, managing medications, moving about outside, shopping for essentials, preparing meals, laundry and light housekeeping.

- **Respite Care** - care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities.

Home Care Services do not include services performed by providers that are not licensed or certified, when such services require licensing or certification under the laws of the states where the services are provided.

"**Plan of Care**" means a program of treatment or care. It must be developed by your **Physician** or multi-disciplinary team and approved, in writing, by your **Physician** before the start of **Home Care Services**. The written **Plan of Care** is subject to updating, in writing, no more often than every 60 days. You will be responsible for submitting:

- the **Physician** approved **Plan of Care**; and
- the periodic updates to such plan.

Respite Care Benefits

If you are eligible for a **Home Care** benefit and are receiving **Home Care Services** under a **Plan of Care** but are not yet receiving monthly payments because you have not yet completed the **Home Care Elimination Period**, we will pay a benefit equal to your daily **Home Care** benefit for each day that you receive **Respite Care**, up to a maximum of 15 days per calendar year.

Respite Care days will not count toward satisfying the **Home Care Elimination Period.**

Payments made to you for **Respite Care** will not reduce your Lifetime Maximum Amount.

Respite Care may be provided to you by any home care provider available under the contract, excluding **Family Members.**

Amount of Home Care Monthly Benefit

The amount of your **Home Care** monthly benefit will be based on the number of days you receive **Home Care Services** each month. You must give us proof of **Home Care Services** received by indicating the days of **Home Care Services** provided to you before a benefit will be paid. If you receive **Home Care Services** every day for a month, then a full monthly benefit will be paid. If you receive **Home Care Services** for less than one month, a benefit will be paid at the rate of 1/30th of the monthly benefit amount for each day you are eligible for a benefit payment. The amount of your full monthly benefit is shown in the SUMMARY OF BENEFITS and on the SCHEDULE OF BENEFITS form attached to and made a part of this Certificate.

Unum will send you a lump sum payment to cover the period between the day you became eligible for monthly benefit payments and the day you were approved for these payments. Unum will then send you a payment each month for the number of days you were eligible to receive benefits during the prior month. Benefit payments will cease as provided in the provision "**WHEN MONTHLY BENEFIT PAYMENTS END**".

Home Care Waiver of Premium

Once a **Home Care** benefit becomes payable, there will be no more cost for your coverage as long as you are **Disabled** and are receiving a **Home Care** monthly

benefit. If benefits are no longer payable, you **must** resume premium payments to continue your coverage.

If you do not receive a **Home Care** benefit for a period of 30 consecutive days, premium payments will again become due.

Premium payments are not waived while you are receiving a payment for **Respite Care**.

We will notify you of the amount of your next premium payment and the date it is due.

WHEN MONTHLY BENEFIT PAYMENTS END

We will continue monthly benefit payments until the earliest of the following dates:

- the date you are no longer **Disabled**;
- the expiration of your **Physician** certification;
- the date you are no longer eligible for a monthly benefit under the plan of coverage you chose;
- the date your total benefit payments equal the Lifetime Maximum Amount; or
- the date you die.

LIMITATION AND EXCLUSIONS

Unum will not make long term care payments to you for **any** benefits for:

- a **Disability** caused by war (whether declared or not) or any act of war;
- a **Disability** caused by intentionally self-inflicted injuries or attempted suicide;
- a **Disability** caused by the commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law;
- **Disabilities** or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- a **Disability** caused by being intoxicated;
- a **Disability** caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a **Physician**;
- a period in which you are confined in a hospital other than if you are confined in a **Nursing Facility** that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit); or
- a **Disability** caused by psychological or psychiatric or mental conditions, regardless of cause, which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia,
  - manic depressive disorders, or
  - adjustment disorders

  and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

  However, Unum will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

PRE-EXISTING CONDITIONS EXCLUSION

A pre-existing condition is any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition,

during the six month period right before your coverage began.

Unum will not make any payments to you for a **Disability** that:

- is caused by, contributed to by, or results from a pre-existing condition, and
- begins during the first six months after your coverage begins.

This pre-existing conditions exclusion will apply to all insurance that does not require evidence of insurability.

"**Pre-Existing Condition**" means any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition,

during the six month period right before your coverage began.

NOTICE OF CLAIM

You must give Unum written notice of claim within thirty (30) days of the date you become **Disabled**. If it is not possible for you to give Unum notice within this time period, it must be given as soon as reasonably possible.

If you do not have a Long Term Care Notice of Claim Form, you can get one from the Policyholder's Plan Administrator, or your Unum representative, or you can notify Unum in writing that you want to make a claim. If you do not receive the form from Unum within 15 days after writing, send Unum proof of the claim without the form.

PROOF OF CLAIM

You must send Unum proof of claim for long term care payments no later than 90 days after the end of your Elimination Period. If you cannot send Unum proof within this 90-day period, you must send Unum proof as soon as it is reasonably possible to do so, but in no event more than one year after the time this proof is required.

The proof of your claim must include:

- the date your **Disability** occurred;
- the cause of your **Disability**;
- the extent of your **Disability**;
- certification by a **Physician** that you are unable to perform (without **Substantial Assistance** from another individual) two or more **ADLs** for at least 90 days, or that you require **Substantial Supervision** by another individual to protect yourself and others from threats to health and safety due to **Severe Cognitive Impairment**;
- your **Plan of Care** developed by a **Physician**
- such other proof as we may deem necessary.

You must give Unum proof of continued **Disability** at intervals requested by us. Such proof must be given within 30 days of our request. If it is not possible for you to give us proof of continued **Disability** within this 30-day period, it must be given as soon as reasonably possible. However, proof of continued **Disability** must be given no later than one year after the time proof is otherwise required.

Claims for a **Home Care** monthly benefit must also include proof of the number of days these services were provided to you under your **Plan of Care**.

Unum may also require a claims assessment as part of the proof of claim. A claims assessment means a review done by Unum or its designated representative to help in evaluating the **Disability**. It may include a face-to-face interview with you at a location selected by Unum or its designated representative.

HOW TO FILE A CLAIM

You must fill out a Long Term Care claim form and send it to Unum. If you do not have enough information to complete the form, you may send in the Notice

of Claim postcard that is attached to the claim form. The claim form must be submitted when all information is available.

After you have filed a claim, Unum may also require you to be examined by a **Physician** or other medical practitioner of Unum's choice. Unum will pay for the examination. Unum can require an examination as often as it is reasonable to do so. Unum may require you or your authorized representative to give authorization to obtain additional medical and nonmedical information as part of the proof of claim.

LEGAL ACTION

You or your authorized representative may not start legal action on your claim before 60 days after proof of loss has been given to Unum or more than 3 years from the time proof of loss was required.

RIGHT OF RECOVERY

Unum has the right to recover any overpayments made because of any error Unum makes in processing your claim.

TERMINATION OF COVERAGE

Your coverage will end on the earliest of these dates:

- the date your total benefit payment equals your Lifetime Maximum Amount,
- the date the Policy ends,
- the date you are no longer an **Active Employee** with the Policyholder,
- the date you no longer work for the Policyholder,
- the end of the period for which premiums were last paid to Unum for your coverage, or
- the date you die.

If you are absent from work at the Policyholder for any reason, you will continue to be covered for group coverage if the Policyholder continues to pay premiums to Unum.

EXTENSION OF BENEFITS

Termination of coverage will not affect any benefits payable if **Disability** began while your long term care insurance was inforce, and continues without interruption after termination. Such extension of benefits will be limited to the duration of the payment of the Lifetime Maximum Amount.

CONTINUATION OF COVERAGE

If group coverage ends, you may elect converted coverage which means that the same coverage you had under this plan can continue on a direct billing basis. If you are already direct billed, your coverage will automatically transfer to converted coverage.

You may not elect converted coverage if your coverage ended because you stopped paying premiums or if you are not insured under this plan.

Election for converted coverage must be made within 31 days of the date the group coverage ends. You must pay premium directly to Unum for any converted coverage to be continued.

The premium rate schedule for converted coverage may change in the future, depending on the overall use of the benefits by all insured persons or changes in the benefit levels or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies.

Once you have converted your coverage, you can apply at any time to change your coverage by contacting Unum's Home Office. You will need to complete the necessary forms which may include evidence of insurability.

STATEMENTS

Unum considers any statements you make for insurance in any signed application(s) for initial coverage and/or any subsequent changes in coverage to be complete and true to the best of your knowledge and belief. All statements made in any application are considered representations and not warranties (absolute guarantees). If any of these statements are not complete and/or not true at the time they are made, Unum can:

- reduce or deny any claim, or
- terminate insurance from the original effective date.

Unum must use only the statements made in the signed application(s) as a basis for doing this.

Except for fraud, Unum can take these actions only in the first 2 years your initial coverage or change in coverage is in force. There is no time limit for Unum to take these actions if any statements are fraudulent.

INCONTESTABILITY

For a certificate that has been in force for less than six (6) months, Unum may rescind coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

For a certificate that has been in force for at least six (6) months but less than two (2) years, Unum may rescind coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

After a certificate has been in force for two (2) years, it is not contestable upon the grounds of misrepresentation alone, such certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevent facts relating to his/her health.

AGENCY

For all purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed Unum's agent.

PREMIUMS

The premium due must be paid within the **Grace Period**. The **Grace Period** is the 45 days immediately following any premium due date during which premium payment must be made. If premium is not paid within this time, your coverage will terminate at the end of the **Grace Period**.

The premium rate will not increase because you grow older or because of your use of the benefits. However, the premium rate schedule may change in the future depending on the overall use of the benefits by all insured persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance.

REINSTATEMENT

If your coverage terminates because a premium is not paid by the end of the grace period, you may request to reinstate your coverage at any time until six months from the coverage termination date.

In order to reinstate your coverage, the following requirements must be met:

- you must complete a reinstatement application;
- Unum must approve that reinstatement application; and
- you must pay all unpaid premium.

If Unum approves your reinstatement application, reinstatement will take effect on the date your coverage was terminated for non-payment of premium.

The reinstated coverage WILL NOT cover any **Disability** which is excluded by name or description in the Policy.

REINSTATEMENT OF TERMINATED COVERAGE DUE TO DISABILITY

If you become **Disabled** and your coverage terminates because premium is not paid by the end of the grace period, you may request to reinstate your coverage at any time until five months from the coverage termination date.

In order to reinstate your coverage, the following requirements must be met:

- you must provide proof that your **Disability** occurred prior to the coverage termination date; and
- you must pay all unpaid premium.

The reinstated coverage WILL NOT cover any **Disability** which is excluded by name or description in the Policy.

POLICY RENEWABILITY

The Policy is renewable at the option of the Policyholder and Unum. This means that your coverage under the plan may be changed or ended at the option of the Policyholder or Unum. If your coverage is ended by the Policyholder or Unum, you will have a guaranteed right to elect continuation of coverage.

IMPORTANT INFORMATION FOR CONNECTICUT RESIDENTS

ENDORSEMENT TO CERTIFICATE OF INSURANCE

If you were a resident of Connecticut when your coverage under the group policy first became effective, and if the provisions referenced below appear in your Certificate of Insurance in a form less favorable to you as an insured, they are changed as follows:

1) The "LIMITATIONS AND EXCLUSIONS" section is changed to state:

Unum will not make long term care payments to you for:

- a Disability cause by war (whether declared or not) or any act of war,
- a Disability caused by attempted suicide (while sane or insane) or self-destruction,
- a Disability caused by the commission of a felony for which you have been convicted under state or federal law,
- disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- a confinement due to alcoholism or drug addiction,
- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hopital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit), or
- a Disability caused by psychological or psychiatric or mental conditions, regardless of cause, which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia,
  - manic depressive disorders, or
  - adjustments disorders

  and other conditions that are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or similar methods of treatment.

However, Unum will make payments to you for conditions that are not psychological, psychiatric or mental in nature, including Alzheimer's disease or similar forms of irreversible dementia.

2) The "**PRE-EXISTING CONDITION**" provision is removed in its entirety and is no longer applicable.

"Pre-Existing Condition" means any condition that exists for you which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition; or
- took drugs or medicines that were prescribed for the condition, during the six (6) month period right before your coverage began.

3) The "**WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT**" section is changed to state:

You are eligible for a Monthly Benefit after:

- you become Disabled;
- your are receiving services in a Long Term Care Facility or Assisted Living Facility; (or Professional Home Care Services if your plan includes a Professional Home Care Services Benefit); (or Total Home Care if your plan includes a Total Home Care Benefit);
- you have satisfied your Elimination Period; and
- a Physician has certified that you are unable to perform (without Substantial Assistance from another individual) two (2) or more ADLs for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you and others from threats to health or safety due to Severe Cognitive Impairment. You will be required to submit a Physician certification every 12 months.

  A Monthly Benefit will become payable once all of these requirements are met.

4) The "**INCONTESTABILITY**" section is changed to state:

For a certificate that has been in force for less than six (6) months, Unum may rescind coverage or deny an otherwise valid long term insurance claim upon showing of misrepresentation that is material to the acceptance for coverage.

For certificate that has been in force for at least six (6) months, but less than two (2) years, Unum may rescind coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation that is **both** material to the acceptance for coverage **and** which pertains to the condition for which benefits are sought.

After a certificate has been in force for two (2) years from its date of issue, it is not contestable, except for nonpayment of premium.

If we have paid benefits under the policy, the benefit payments may not be recovered by us in the event that the coverage is rescinded.

Important: This document becomes part of your Certificate of Insurance. Be sure to keep this document in your records with the Certificate of Insurance previously provided to you under the group policy.

Additional Summary Plan Description Information

If this Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the Summary Plan Description. The Summary Plan Description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

Name of Plan:
PADI Worldwide Corp. Plan

Name and Address of Employer:
PADI Worldwide Corp.
30151 Tomas Road
Rancho Santa Margarita, CA 92688

Plan Identification Number:
a. Employer IRS Identification #: 95-3872901
b. Plan #: 501

Type of Welfare Plan:
Long Term Care

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

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address and Telephone No.:
PADI Worldwide Corp.
30151 Tomas Road
Rancho Santa Margarita, CA 92688
949-798-1292

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

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

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

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number/identification number 544252. Contributions to the Plan are made as stated under the Summary of Benefits in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

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

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The Policy or a plan under the Policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may terminate the Policy by written notice of at least 45 days if:

- the Employer does not promptly give Unum any information that Unum requires; or
- the Employer fails to perform any of its obligations that relate to the Policy.

The Policy will automatically terminate if the Employer does not pay all premiums due within the Grace Period. The Policy will terminate at 12:00 midnight on the last day of the Grace Period.

The Employer must pay all the premiums for the entire time that the Policy is in effect and will be liable to Unum for any premiums that it does not pay.

However, Unum cannot refuse to renew or otherwise terminate this Policy because the insured persons grow older or because of the insured persons' use of benefits.

The Employer can terminate the Policy on any date if it delivers written notice to Unum at least 45 days before the termination date.

If the Employer and Unum both agree, the Policy may be terminated less than 45 days after the Employer or Unum gives notice of termination. However, the Policy will not be terminated during any period for which the Employer has paid premium.

If the Policy is terminated, Unum will still pay any payable claim for an insured person's Disability which began while the Policy was in effect.

HOW TO FILE A CLAIM

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

CLAIM PROCEDURES

The time periods provided in this section will apply to claims procedures under the Policy unless a shorter time period is stated in the Policy.

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

1. the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and

3. a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

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

APPEAL PROCEDURES

The time period provided in this section for submitting an appeal will apply unless a longer time period for submitting an appeal is stated in the Policy.

The time period provided in this section for making a final appeal decision will apply unless a shorter time period for making a final appeal decision is stated in the Policy.

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

1. submit a request for review, in writing, to Unum;

2. upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

3. submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Policy provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring lawsuit under Section 502(a) of ERISA if you disagree with the determination.

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

DISCRETIONARY ACTS

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

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