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. The Policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Policy Number: 113509 001

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: This Certificate is guaranteed renewable on each Policy Anniversary as long as the Policyholder continues to remit all premiums due within the Grace Period. Termination will occur only if the Policyholder fails to pay the premiums. If the Policy is terminated, all insured persons will have a guaranteed right to elect Continuation of Coverage. The premiums under the Policy may be changed on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

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 TO YOU WITHIN 30 DAYS AFTER RECEIPT OF YOUR WITHDRAWAL.

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.

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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. IN ADDITION, IF THIS CERTIFICATE PROVIDES OPTIONAL INFLATION PROTECTION AND YOU DO NOT CHOOSE IT, YOU ARE ADVISED THAT, BASED ON CURRENT HEALTH CARE COST TRENDS, YOUR BENEFITS MAY BE SIGNIFICANTLY DIMINISHED IN TERMS OF REAL VALUE, DEPENDING ON THE AMOUNT OF TIME WHICH ELAPSES BETWEEN THE DATE OF PURCHASE AND THE DATE UPON WHICH YOU FIRST BECOME ELIGIBLE FOR THOSE BENEFITS.

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 CP&Y, Inc. and its covered divisions, subsidiaries, and affiliated companies.

President

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unum's toll-free telephone number for information or to make a complaint at:

1-800-321-3889
OPTION NUMBER 2

You may also write to Unum at:

Deborah J. Jewett, Manager
Customer Relations
Unum Life Insurance Company
of America
2211 Congress Street
Portland, Maine 04122

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

1-800-252-3439

You may also write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007

Web: www.tdi.texas.gov

E-Mail: ConsumerProtection(a)
tdi.texas.gov

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(TDI).

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Unum's para obtener informacion o para presentar una queja al:

1-800-321-3889
OPCION NUMERO 2

Usted tambien puede escribir a Unum:

Deborah J. Jewett
Gerente de Relaciones al Cliente
Unum Life Insurance Company
of America
2211 Congress Street
Portland, Maine 04122

Usted puede communicarse con el Departamento de Seguros de Texas para obtener informacion sobre de companias, cobertura, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007

Web: www.tdi.texas.gov

E-Mail: ConsumerProtection(a)
tdi.texas.gov

DISPUTAS POR PRIMAS DE DE SUGUROS O RECLAMACIONES:

Si tiene una disputa relacionado con su prima de seguro con una reclamacion, usted debe comunicarse con la compania primero.
Si la disputa no es resuelta, puede comunicarse con el Departamento de Seguros de Texas(TDI).

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SUMMARY OF BENEFITS

	Available January 1, 2004 Active Employees- At the Employer's expense	Available January 1, 2004 Family Members At your expense
Monthly Benefit Maximum		
Long Term Care (LTC) Facility	$3,000	$2,000 to $8,000 in $1,000 increments
Assisted Living Facility	60% of the LTC Facility amount	60% of the LTC Facility amount
Professional Home Care Services	50% of the LTC Facility amount	50% of the LTC Facility amount **OR**
Total Home Care		50% of the LTC Facility amount
Uncapped Compound Inflation Protection		5% compounded annually
Lifetime Maximum Amount	36X the LTC Facility amount	36X the LTC Facility amount **OR** 72X the LTC Facility amount **OR** Unlimited
Elimination Period	90 consecutive days	90 consecutive days

	Available March 1, 2004 Active Employees- At your expense
Monthly Benefit Maximum	
Long Term Care (LTC) Facility	$1,000 to $5,000 additional coverage in $1,000 increments
Total Home Care	50% of the LTC Facility amount
Other Coverage Options	
Uncapped Compound Inflation Protection	5% compounded annually
Lifetime Maximum Amount	72X the LTC Facility amount OR Unlimited

Evidence of Insurability Limits

If you choose any of the following benefits, you will be required to complete an Application for Long Term Care Insurance, which includes Evidence of Insurability:

- Monthly Benefit Maximum Amount(s) greater than $6,000; and
- an "Unlimited" Lifetime Maximum Amount.

These amounts are known as Evidence of Insurability Limits.

If you apply for benefits that exceed the Evidence of Insurability Limits and are approved, the "PRE-EXISTING CONDITIONS LIMITATION" will be waived for your entire amount(s) of insurance. If Unum disapproves your Application for Long Term Care Insurance, you will be insured for the amount(s) selected up to the amount that does not exceed the Evidence of Insurability Limit(s). The "PRE-EXISTING CONDITIONS LIMITATION" will apply.

"Unlimited" Lifetime Maximum Benefit Amount means your Maximum Benefit Amount will not be limited to any dollar amount.

CHANGES IN COVERAGE

For an Active Employee and the spouse of an Active Employee

You can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the later of:

- the first of the month after Unum approves your application, if approval is between the first and the fifteenth of the month; or
- the first of the second month after Unum approves your application, if approval is between the sixteenth and the end of the month.

The premium rate to be paid for any change 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 change in coverage.

For all other insured persons

You can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the first of the month after Unum approves your application.

The premium rate to be paid for any change 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 change in coverage.

WHEN CHANGES IN COVERAGE WILL BE DELAYED

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.

TERMS YOU SHOULD KNOW

When you see these words, here's what Unum means:

"**Active Employee**" means a consulting engineer working for the Policyholder:

- on a full-time basis for earnings that are paid regularly;
- for a minimum of 20 hours per week; and
- at the Policyholder's usual place of business or at a location to which their job requires them to travel.

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

- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the task 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 or out of a bed, chair, or wheelchair or to move from one location to another, indoors and outdoors, either via a walker, a wheelchair or other means.
- CONTINENCE - the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"**Adult Day Care**" means a social and health-related services program provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other Disabled adults who can benefit from care in a group setting outside the home.

"**Adult Day Care Facility**" means a facility which operates pursuant to federal and state law, and provides Adult Day Care on a daily or regular basis, but not overnight, to adults who are not related by blood, marriage, or adoption to the owner of the facility.

"**Assisted Living Facility**" means an institution that operates pursuant to state and federal law or a similar facility approved by Unum.

An Assisted Living Facility **does not** include:

- any home, facility, or part thereof used primarily for rest; or
- a home or facility for the aged or for the care of drug addicts or alcoholics; or
- a home or facility primarily used for the care and treatment of mental diseases or disorders; or
- a home or facility used for custodial or educational care.

"**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.

"**Elimination Period**" means the number of consecutive days during which you must be Disabled and under the regular care of a Physician before benefits become payable.

If your plan includes Professional Home Care Services, each calendar week that you receive at least one day of these services will be counted as seven days towards completing the Elimination Period. However, if you do not receive these services for at least one day within a calendar week, the Elimination Period will begin again.

"**Family Members**" means:

- the legally married spouse of an Active Employee;
- the natural, adoptive or step-parents/grandparents of an Active Employee and their spouse;
- the natural, adoptive or step-siblings of an Active Employee and their spouse;
- the natural, adoptive or step-children of an Active Employee and their spouse.

Family Members who are eligible for coverage as an Active Employee are only eligible for coverage as an employee.

To be eligible for coverage, Family Members must be between the ages of 18 and 80.

"**Grace Period**" means the 65 days immediately following any premium due date during which premium payment must be made.

"**Home Health Care Agency**" means a business which provides home health care services and is licensed by the Texas Department of Health. Home health care services are medical or nonmedical services provided to ill, Disabled or infirm persons in their residences. Such services may include homemaker services, assistance with Activities of Daily Living, respite care services, case management services and maintenance of personal care services.

"**Hospice Care**" means a formal program of care for terminally ill patients whose life expectancy is less than 6 months, provided on an inpatient basis and directed by a Physician in a Hospice Care Facility that is licensed, certified or registered in accordance with state law.

"**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.

"**Lifetime Maximum Amount**" means the maximum Unum will pay you for all long term care benefits. You have your own Lifetime Maximum Amount.

"**Long Term Care Facility**" means an institution that operates pursuant to state and federal law. However, Unum may approve a similar institution if such institution is not required to be licensed.

A Long Term Care Facility **does not** include:

- any home, facility, or part thereof used primarily for rest; or
- a home or facility for the aged or for the care of drug addicts or alcoholics; or
- a home or facility primarily used for the care and treatment of mental diseases or disorders; or
- a home or facility used for custodial or educational care.

"**Physician**" means a person 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 Unum for long term care insurance:

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

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

- received or were recommended medical advice or 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.

"**Professional Home Care Services**" means:

- visits to your residence by a Home Health Care Agency to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services. Each one hour or more per day of a Home Health Care Agency's services will be considered one visit;
- Adult Day Care; or
- Hospice Care.

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

Professional Home Care Services do not include services performed by your spouse, daughter, son, parent, sister, brother, grandparent or grandchild through a Home Health Care Agency or an Adult Day Care Facility.

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

"**Severe Cognitive Impairment**" means a deterioration or loss in intellectual capacity, requiring Substantial Supervision by another individual for the purpose of protecting you from harming yourself or others, as measured by clinical diagnosis by a Physician authorized to make such a diagnosis. The diagnosis will include your:

- medical history;
- physical, neurological, psychological and/or psychiatric evaluations; and
- laboratory findings.

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.

"**Total Home Care**" means:

- visits to your residence by a Home Health Care Agency to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services;
- Adult Day Care;
- Hospice Care; or
- care provided by an informal caregiver, such as a friend or relative.

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

BENEFIT INFORMATION

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You are eligible for a Monthly Benefit if, after the effective date of your coverage and while your coverage is in effect,:

- you suffer the loss of 2 or more ADLs; or
- you suffer Severe Cognitive Impairment; and
- you 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 Service Benefit);(or Total Home Care if your plan includes a Total Home Care Benefit);
- you have satisfied your Elimination Period; and
- a Licensed Health Care Practitioner has certified that you are unable to perform (without Substantial Assistance from another individual) two 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 Licensed Health Care Practitioner certification every 12 months.

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

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

AMOUNT OF MONTHLY BENEFIT

The amount of your monthly benefit will be based on the coverage options you chose from the SUMMARY OF BENEFITS and the place of residence used for long term care. See your SCHEDULE OF LONG TERM CARE BENEFITS form to determine the amount we will pay you each month.

If your plan includes Professional Home Care Services, the benefit payment will be based on the number of days you receive these services each month.

A monthly benefit payable for less than one month will be paid at the rate of 1/30th of the monthly benefit amount for each day you are eligible for a monthly benefit.

WHEN MONTHLY BENEFITS ARE PAID

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 days you were eligible to receive benefits during the prior month. However, if you die during a period in which payment is due, payment may be made to the executor or administrator of your estate.

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 Licensed Health Care Practitioner 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.

WAIVER OF PREMIUM

Once benefits become payable, there will be no more cost for your coverage as long as you are Disabled. If you do not receive Professional Home Care Services for a period of 30 consecutive days, premium payments will again become due. If benefits are no longer payable, you **must** resume premium payments to continue your coverage. Premiums are **not waived** while you are receiving a payment for Respite Care.

RECURRENT DISABILITY

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

RESPITE CARE BENEFITS

If you are eligible for a home care benefit but are not yet receiving monthly payments because you:

- have not yet completed the Elimination Period; or
- have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount

we will pay a benefit equal to 1/30th of your home care benefit for each day that you receive Respite Care up to a maximum of 15 days per calendar year.

Payments made to you for Respite Care will reduce your Lifetime Maximum Amount.

Respite Care may be provided to you by:

- a formal caregiver, such as a Home Health Care Agency, an Adult Day Care Facility, a registered nurse, a licensed practical nurse, etc., or
- an informal caregiver such as your friends or relatives.

BED RESERVATION BENEFIT

If you are receiving a Long Term Care Facility or Assisted Living Facility 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 Elimination Period, such days will be used to help satisfy this period.

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

INFLATION PROTECTION

Uncapped Compound Growth Inflation Protection Option

If you have chosen this option, your Monthly Benefit will increase each year on January 1st by 5% of the Monthly Benefit in effect on that date. As long as your coverage remains in effect, inflation increases will occur automatically for your Monthly Benefit Amount and Lifetime Maximum Amount as shown in the SUMMARY of BENEFITS, regardless of your health or whether or not you are Disabled. Your premium will not increase due to automatic increases in these amounts.

An example of a 5% uncapped compound growth inflation protection increase is:

An LTC Facility Monthly Benefit amount of $1,000 will be increased:
1. by 5% to $1,050 on January 1st of the next calendar year;
2. by 5% of $1,050 to $1,102.50 on the next January 1st; and
3. by 5% of the previous benefit amount on each following January 1st.

CONTINGENT NONFORFEITURE BENEFIT

If your premium rates increase to a level which results in a cumulative increase of your annual premium equal to or exceeding the percentage of your initial annual premium shown in the chart below, based on issue age, you may choose to do one of the following:

1. continue to pay the required premium;
2. decrease your coverage, without additional underwriting, so that premium payments are not increased;
3. elect to convert your coverage within 120 days of the premium increase effective date to a paid-up status with the Contingent Nonforfeiture Benefit; or
4. terminate your coverage within 120 days of the premium increase effective date and be automatically converted to the Contingent Nonforfeiture Benefit.

The percentage increase in premium does not include increases to premium due to changes to your Long Term Care insurance coverage.

If you stop making premium payments under items 3 and 4, this means that your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Amount. Your Lifetime Maximum Amount under this Contingent Nonforfeiture Benefit will be equal to the total premium paid up to the date you stopped paying premiums.

In no event will your Lifetime Maximum Amount:

- be less than one Long Term Care Facility Monthly Benefit payment amount; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains an inflation protection benefit and continues under the Contingent Nonforfeiture Benefit, no inflation protection increases will be made after the end of the period for which premiums were last remitted to Unum for your coverage.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 & Under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

PLAN EXCLUSIONS

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

- a Disability caused by war (whether declared or not) or any act of war,
- a Disability caused by attempted suicide (while sane or insane) or intentional self-destruction,
- a Disability caused by a 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 alcoholism or alcohol abuse,
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- 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:
  - neurosis,
  - psychoneurosis,
  - psychopathy,
  - psychosis, or
  - mental or emotional disease or disorder of any kind

  whether treated by drugs, counseling or other forms of therapy.

  However, Unum will make payments to you for conditions that are not mental or nervous in nature, including Alzheimer's disease, biologically-based brain diseases and serious mental illness including:

  - schizophrenia,
  - paranoid and other psychotic disorders,
  - bipolar disorders (mixed, manic and depressive),
  - major depressive disorders (single episode or recurrent) and
  - schizo-affective disorders (bipolar or depressive).

PRE-EXISTING CONDITIONS LIMITATION

A Pre-Existing Condition is any condition that exists for which you:

- received or were recommended medical advice or 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 monthly benefit payments to you during the first six months after your coverage begins if your eligibility for the monthly benefit is based on Severe Cognitive Impairment or the loss of an ADL that:

- is caused by, contributed to by, or results from a Pre-Existing Condition, and
- is present during the first six months after your coverage begins.

This Pre-Existing Conditions limitation will apply to all insurance that does not require evidence of insurability.

REHABILITATION AND ALTERNATE CARE PLANS

While you are Disabled, we may suggest special services and /or equipment designed to help you regain the ability to independently perform the Activities of Daily Living. The services and/or equipment must be medically necessary and appropriate for your Disability and provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner. The services or equipment must be intended to assist you in living at home or other residential housing by eliminating your need for Substantial Assistance. The services or equipment cannot be covered by other insurance or Medicare. Examples of Alternate Care Plans may include, but are not limited to:

- a rehabilitation program;
- home modifications for wheelchair access; and
- certain types of medical equipment, emergency medical response systems or hardware purchases.

The terms of an Alternate Care Plan and the actual expenses that Unum will pay will be subject to written mutual agreement between Unum, you and your Physician.

If, for any reason, you do not wish to participate in an Alternate Care Plan, your benefits will continue according to the provisions of the Policy.

CLAIM INFORMATION

NOTICE OF CLAIM

You must give us written notice of claim within thirty (30) days of the date you become Disabled. If it is not possible for you to give us 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 date you become Disabled. 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, unless you are legally incapacitated.

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 Licensed Health Care Practitioner 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 written plan of care developed by a Licensed Health Care Practitioner;
- 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 possible. However, proof of continued Disability must be given no later than one year after the time proof is otherwise requested, unless you are legally incapacitated.

Claims for a Professional Home Care Services monthly benefit must also include proof of the number of days these services were provided to you.

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.

Benefits payable under the Policy become payable within 60 days after the receipt of proof of claim.

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.

CLAIM DENIAL

If your claim is denied, we shall make available all information directly related to such denial within 60 days of the date of your written request, unless such disclosure is prohibited under state or federal laws.

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 payments equal your Lifetime Maximum Amount; or
- the date the Policy ends; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you are no longer an Active Employee with the Policyholder; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you no longer work for the Policyholder; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you request to terminate 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

You may elect to continue the same coverage you had under the group policy on a direct billing basis, if your group coverage ends. **You may not elect to continue coverage if you are not insured under the group policy. You may not elect to continue coverage if your group coverage ended because:**

- **you failed to make any required premium payment when due; or**
- **you failed to make any contribution when due.**

Election for continued coverage must be made within 31 days from:

- the date your group coverage ends; or
- the date the group policy terminates.

Your continued coverage will be on a direct billing basis, if your premium is payroll deducted. Your continued coverage:

- will be maintained under the existing group policy, if your coverage terminated because you are no longer eligible for coverage; or
- will be continued under a continuation group policy, if the existing group policy terminates.

If you are already direct billed, your coverage will automatically continue:

- under the existing group policy, if you are no longer eligible for coverage; or
- under a group continuation policy, if the existing group policy terminates.

Your continued coverage will remain in force, as long as you continue timely payment of premium when due. You must pay premium directly to Unum for continued coverage.

The premium rate schedule for continued 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 continued your coverage, you can apply at any time to change your continued coverage. To change your coverage, you must contact Unum's home office. You will need to complete the necessary forms, which may include evidence of insurability.

GENERAL INFORMATION

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 two (2) years, Unum may rescind your coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation, or an intent to deceive by you in your application for insurance.

After a certificate has been in force for two (2) years, such certificate may be contested only upon a showing that you knowingly and intentionally provided fraudulent information relevant to facts relating to your health, or for nonpayment of premium.

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 by the premium due date or within the 65 day Grace Period. If premium is not paid within this time, your coverage will terminate.

If premium is not paid by the premium due date, you will receive written notification from Unum that your coverage will terminate. This notification will not be given until thirty (30) days after a premium is due and unpaid. If you have designated another person to receive notification of termination of insurance for nonpayment of premium, this notice will also be sent to him/her.

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 65 day 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;
- we must approve that reinstatement application; and
- you must pay all unpaid premium.

If we approve the reinstatement application, we will reinstate your coverage on the approval date. If we issue a prepayment agreement and do not approve or disapprove the reinstatement application within 45 days from the date of the prepayment agreement, we will reinstate your coverage on that 45th day.

If the Policy is reinstated, it will only cover losses incurred on or after the date the policy is reinstated. In all other respects, upon reinstatement, all of the provisions under the Policy immediately before the due date of the defaulted premium will resume.

The reinstatement 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 65 day 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.

If you meet these requirements, we will reinstate your coverage on the coverage termination date.

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

POLICY RENEWABILITY

The Policy is guaranteed renewable on each Policy Anniversary as long as the Policyholder continues to remit all premiums due within the Grace Period. Termination will occur only if the Policyholder fails to pay the premiums. If your coverage is ended by the Policyholder, all insured persons will have a guaranteed right to elect continuation of coverage. However, the right to elect continuation of coverage does not apply if your coverage ends because you stopped paying premiums.

The premiums under the Policy may be changed on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

FEDERAL INCOME TAX TREATMENT OF THE POLICY

The Health Insurance Portability and Accountability Act of 1996 granted favorable federal income tax treatment of qualified long term care policies. To the best of our knowledge, the Policy was designed to meet the requirements of this new law. If, in the future, it is determined that the Policy does not meet these requirements, we will make every reasonable effort to amend the Policy in order to gain such favorable federal income tax treatment. Such amendment must be filed and approved by the appropriate insurance department prior to issuance. You will be offered the opportunity to receive these amendments.

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:
CP&Y, Inc. Plan

Name and Address of Employer:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235

Plan Identification Number:
a. Employer IRS Identification #: 75-1720414
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.:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235
(214)640-1703

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

Agent for Service of Legal Process on the Plan:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235

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 113509 001. 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:

- fewer than 10 employees insured under a Plan; or
- 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.

UNUMPROVIDENT

APPLICATION FOR GROUP INSURANCE

Underwritten by: Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122

Name of Applicant: CHIANG, PATEL & YERBY, INC.

Address: 1820 RELIANCE ROW, Suite 200
(Street)

(City) DALLAS (State) TEXAS (Zip) 75235

applies to the Unum Life Insurance Company of America, for:

- ☐ Group Life Benefits
- ☐ Group Accidental Death and Dismemberment Benefits
- ☐ Group Short Term Disability Benefits
- ☐ Group Long Term Disability Benefits
- ☑ Group Long Term Care Benefits

Is there any group life insurance plan in force or being applied for on some or all employees? ☑ Yes ☐ No
If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates	Termination Dates
ALL		UNUM		

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The policy specifications will be made a part of the policy along with a copy of this form.

Dated at DALLAS, TEXAS

on Nov. 14, 2003 By: DAVID HAYS (Applicant) David Hays (Signature and Title)

Producer Name: David B. Ciraolis (Please Print) Producer Signature: X David B. Ciraolis

SS# / Tax ID#: 36-4291971 State ID #: _____ Policy Effective Date: 1-1-04

PRODUCER INFORMATION: For commission purposes, please list the brokers/agents for this application. Use full names, including complete business names. To ensure proper payment of commissions, include each producer's tax identification number (social security number or corporate tax id) and state identification number where applicable. If more than one producer, please be sure to specify the split %. For corporate producers, please specify the signing representative's name and ID #'s.

PLEASE PRINT ALL INFORMATION CLEARLY

	Producer Name (Please print full names)	SS# / Tax ID#	State ID# (where applicable)	Split % age (Must total 100%)	Unum Producer # (If known)
1.	David B Ciraolis	36-4291971		100	510469
2.					
3.					
4.					

514-61

(6/02)

UnumProvident's Committment to Privacy

UnumProvident understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information

We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information

We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. **When legally necessary, we ask your permission before sharing NPI about you.** Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. **When required by law, we ask your permission before we share NPI for marketing purposes.**

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

UnumProvident companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

Access of Information

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information

If you believe NPI we have about you is incorrect, please write us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us

For additional information about UnumProvident's commitment to privacy, please visit www.unumprovident.com/privacy or www.colonialife.com or write to: Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

UnumProvident Corporation is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life and Accident

Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

UNUMPROVIDENT'S NOTICE OF PRIVACY PRACTICES

For Long Term Care, Cancer Assistance, Certain Medical Coverages and other Health Plans*
Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UnumProvident Understands the Importance of Your Privacy

This Notice describes your rights concerning "protected health information" ("PHI") about you. PHI is information that may identify you and that relates to (a) your past, present, or future physical or mental health or condition or (b) the past, present or future payment for your health care.

UnumProvident is committed to preserving the confidentiality of PHI about its customers and in accordance with the requirements of the law, we pledge to:

- maintain the privacy of PHI about you
- provide you with a notice of our legal duties and privacy practices with respect to PHI
- abide by the terms of our current notice of privacy practices

It may be necessary to change the terms of this notice in the future. We reserve the right to make changes and to make the new notice effective for all PHI that we maintain about you, including PHI we created or maintained in the past. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by a health plan.

Uses and Disclosures of PHI for Treatment, Payment or Operations

- *For Treatment* - UnumProvident is not a health care provider and does not engage in "treatment" of individuals as a health care provider (a doctor, for example) would. Accordingly, although we are permitted to use or disclose PHI about you for treatment purposes, we do not do so.
- *For Payment* - We may use and disclose PHI about you in order to obtain premiums or to determine or fulfill our responsibility to provide you with insurance coverage or benefits under your policy. For example, we may use or disclose PHI about you in order to determine whether you are eligible for coverage or to decide your claim for benefits under your policy.
- *For Health Care Operations* - We may use and disclose PHI about you in order to operate our business. For example, we use PHI about you in order to underwrite your insurance policy.

*A "health plan" under the HIPAA Standards for Privacy of Individually Identifiable Health Information is an individual or group plan that provides or pays the cost of medical care.

(continued)

Uses and Disclosures in Special Circumstances

Public Health Activities. We may disclose PHI about you in order to notify public health authorities of public health risks, such as potential exposure to a communicable disease, or to report child abuse or neglect.

Health Oversight Activities. We may disclose PHI about you to a health oversight agency for oversight activities, including for investigations relating to possible insurance fraud.

Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding, such as in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may disclose PHI to law enforcement, for purposes such as reporting a crime on our premises or in an emergency. We may also disclose to law enforcement or a correctional facility PHI relating to inmates as necessary for health, safety and security.

Prevention of Serious Harm. We may use or disclose PHI about you if we believe it is necessary to prevent or lessen serious harm (abuse, neglect, or domestic violence) to you or to other potential victims.

Serious Threat to Health/Safety. We may use or disclose PHI when it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Specialized Government Functions. We may use or disclose PHI about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities.

Workers' Compensation. We may disclose PHI about you in order to comply with workers' compensation laws.

Research Organizations. We may disclose PHI to research organizations if the organization has satisfied certain conditions about protecting the privacy of PHI.

Plan Sponsors. We may disclose PHI to the plan sponsor of a group health plan for plan administrative functions if the plan documents contain provisions concerning restrictions on how the plan sponsor may use or further disclose PHI.

Related Benefits and Services. We may contact you to inform you of benefits or services related to your policy that may be of interest to you.

Decedents. We may disclose PHI to a coroner, medical examiner, or funeral director to permit them to carry out their legal duties.

Donation/Transplantation. We may use or disclose PHI for the purpose of facilitating organ, eye or tissue donation and transplantation.

Business Associates. We may disclose PHI to our business associates, such as our third-party administrators, accountants, or attorneys if those business associates have signed a written agreement concerning appropriate uses and disclosures of PHI.

Involvement in Individual's Care. We may disclose PHI about you to a family member, close personal friend or other person identified by you if directly relevant to that person's involvement with your care or payment related to your health care.

Notification of Location/Condition. We may use or disclose PHI to give notice or assist in giving notice of your location, general condition or death to a family member, personal representative or another person responsible for your care.

(continued)

Disclosures Required by Law. We will use and disclose PHI about you when we are required to do so by federal, state, or local law.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, we will restrict our uses or disclosure of PHI in accordance with the more stringent standard.

Uses and Disclosures of PHI Made Only With Your Written Authorization

Other uses and disclosure of PHI about you will be made only with your written authorization, unless otherwise permitted or required by law as described in this notice. You may revoke your written authorization, at any time, in writing, except to the extent we have taken action in reliance on that written authorization before you have revoked it. You may not revoke your authorization to the extent that other law provides us with the right to contest a claim under the policy or the policy itself, if the authorization was obtained as a condition of obtaining insurance coverage.

Your Rights

Right to a Paper Copy of this Notice. An electronic copy of this Notice is available on our website, www.unumprovident.com. If you would like to have another paper copy of this Notice, send a written request to the UnumProvident Privacy Officer.

Inspection and Copying. You have the right to access your information. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). You have the right, upon written notice, to inspect and copy certain PHI that may be used to make decisions about your insurance coverage, including medical records and billing records, but not including psychotherapy notes. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

Amendment. You may ask us to amend PHI about you (as long as the information is kept by or for us) if you believe it is incorrect or incomplete. Such requests must be in writing to the Privacy Officer and must include a reason for the request. If your request and a reason supporting the request are not submitted in writing, we may deny your request.

Alternative Contact Information. You have the right to receive communications of PHI about you from us in a certain manner or at a certain location, so long as the request is reasonable under the circumstances. For example, you may prefer to have mail from us sent to your work address rather than to your home. Submit requests for an alternative method of contact in writing to the Privacy Officer.

Requesting Restrictions. You have the right to request restrictions on our use or disclosure of PHI about you. We are not required to agree to your request. If we do agree, however, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary for your treatment. Your request must clearly and concisely describe (a) the information you wish restricted; (b) whether you are requesting to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

(continued)

Accounting. You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures we have made of PHI about you other than disclosures you authorized and other than disclosures made for treatment, payment or operations. The request must be in writing. The first request for an accounting that you make within a 12-month period is free; however, we may charge you for additional requests within the same 12-month period. We will notify you of the costs of the additional requests, and you may withdraw your request before incurring any costs.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. All complaints must be submitted in writing. We will not penalize you for filing such a complaint.

In order to exercise any of your rights as set forth in this Notice, please write to:

Privacy Officer
UnumProvident Corporation
2211 Congress Street, M385
Portland, ME 04122

For further information about matters covered by this notice, please contact the Privacy Office at the above address or call 1 (800) 227-4165 if you are a Long Term Care customer or 1 (800) 635-5597 if you are a Cancer Assistance customer.

UnumProvident Corporation is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company. UnumProvident is the marketing brand of, and refers specifically to, UnumProvident Corporation's insuring subsidiaries.

Effective Date of This Notice: April 14, 2003

G-73568 (4-03)

Group Long Term Care Insurance Policy

POLICYHOLDER:	CP&Y, Inc.
POLICY NUMBER:	113509 002
POLICY EFFECTIVE DATE:	March 1, 2004
PREMIUM DUE DATES:	March 1, 2004 and the first day of each following month
GOVERNING JURISDICTION:	TEXAS
POLICY ANNIVERSARY:	January 1, 2005 and each following January 1

This policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Unum Life Insurance Company of America will pay the benefits provided in this Policy. Unum makes this promise subject to all of this Policy's provisions. Throughout this Policy, Unum means Unum Life Insurance Company of America.

The Policyholder should read this Policy carefully and contact Unum with any questions.

This Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974.

Signed for Unum at Portland, Maine on the Policy Effective Date.

Secretary

President

Unum Life Insurance Company of America

TQGLTC952

ELIGIBILITY

Active Employees of the Policyholder, and their Family Members are eligible for coverage under the Policy. Temporary or seasonal employees are not eligible. Refer to the **TERMS YOU SHOULD KNOW** section for the definitions of Active Employees and Family Members.

The Policyholder is CP&Y, Inc. and its following divisions, subsidiaries and affiliated companies:

NONE

When Active Employees become eligible to apply for coverage:

An Active Employee must continuously meet the definition of Active Employee to be eligible to apply for coverage.

When Family Members become eligible to apply for coverage:

Family Members will be eligible to apply for coverage on the date the Active Employee is eligible to apply for coverage. Family Members who are eligible to apply for coverage as an Active Employee are only eligible to apply for coverage as an employee.

APPLICATION FOR COVERAGE

When Eligible Persons Can Apply:

- **For an Active Employee:**

  The period of time beginning on the date the Active Employee becomes eligible for coverage and ending 30 days after that date is called the first enrollment period.

  - **During the first enrollment period,** the Active Employee can apply for coverage without evidence of insurability for amounts that **do not** exceed evidence of insurability limits. Evidence of insurability will be required if the Active Employee is applying for coverage amounts that **do** exceed the evidence of insurability limits, as shown on the SUMMARY OF BENEFITS.
  - **After the first enrollment period,** the Active Employee can apply for coverage with evidence of insurability.

- **For all other eligible persons:**

  An eligible person can apply for coverage, with evidence of insurability, any time after the date the person becomes eligible for coverage.

How to Apply:

For an Active Employee:

- **During the first enrollment period,** the Active Employee can apply for coverage by filling out a Benefit Election Form. An Application for Long Term Care Insurance which includes evidence of insurability will be required if the Active Employee is applying for coverage amounts that exceed the evidence of insurability limits.
- **After the first enrollment period,** the Active Employee can apply for coverage by filling out a Benefit Election Form and an Application for Long Term Care Insurance which includes evidence of insurability.

For all other eligible persons:

Apply for coverage by filling out a Benefit Election Form and an Application for Long Term Care Insurance which includes evidence of insurability.

Evidence of insurability includes not only the information supplied on the Application for Long Term Care Insurance, but also may include other proof of medical history such as test results, medical exams, Physicians' statements, etc. Unum will pay the costs it determines are necessary to obtain any evidence of insurability it requires.

Unum may also request that an insurability assessment be performed. An insurability assessment is a review done by Unum or its designated representative to help in evaluating a person's cognitive and functional status. It may include:

- a telephone interview with the person; or
- a face to face interview with the person at a location selected by Unum or its designated representative.

Unum will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or decline an Application for Long Term Care Insurance.

WHEN COVERAGE BEGINS

For an Active Employee

- **Coverage applied for within the employee's first enrollment period that does not exceed evidence of insurability limits** will begin at 12:01 a.m. on the later of:
  - the Policy Effective Date; or
  - the first of the month on or next following the month in which the employee applied for coverage.
- **Coverage applied for within the employee's first enrollment period that does exceed evidence of insurability limits** will begin at 12:01 a.m. on the later of:
  - the Policy Effective Date if Unum approves the employee's Application for Long Term Care Insurance on or before that date, or

- the first of the month after Unum approves the employee's Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

- the first of the second month after Unum approves the employee's Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

- **Coverage applied for after the employee's first enrollment period** will begin at 12:01 a.m. on the later of:

  - the first of the month after Unum approves the employee's Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

  - the first of the second month after Unum approves the employee's Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

For the spouse of an Active Employee

Coverage applied for will begin at 12:01 a.m. on the later of:

- the Policy Effective Date if Unum approves the spouse's Application for Long Term Care Insurance on or before that date; or

- the first of the month after Unum approves the spouse's Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

- the first of the second month after Unum approves the spouse's Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

For all other eligible persons

Coverage applied for will begin at 12:01 a.m. on the later of:

- the Policy Effective Date if Unum approves the eligible person's Application for Long Term Care Insurance on or before that date; or

- the first of the month after Unum approves the eligible person's Application for Long Term Care Insurance.

CHANGES IN COVERAGE

For an Active Employee and the spouse of an Active Employee

An Active Employee or their spouse can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the later of:

- the first of the month after Unum approves the employee or spouse's Application for Long Term Care Insurance, if approval is between the first and the fifteenth of the month; or

- the first of the second month after Unum approves the employee or spouse's Application for Long Term Care Insurance, if approval is between the sixteenth and the end of the month.

The premium rate to be paid for any change in coverage is based on the employee or spouse's insurance age. To determine insurance age, subtract the employee or spouse's date of birth from the date the person is applying for the change in coverage.

For all other insured persons

An insured person can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the first of the month after Unum approves the insured person's Application for Long Term Care Insurance.

The premium rate to be paid for any change in coverage is based on the insured person's insurance age. To determine insurance age, subtract the insured person's date of birth from the date the person is applying for the change in coverage.

WHEN COVERAGE WILL BE DELAYED

Active Employees' initial coverage will not begin if they are absent from work because they 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 the Active Employee returns to work as an Active Employee.

GENERAL INFORMATION

The entire contract for the Policyholder consists of:

- This Policy and any attachments issued to the Policyholder.
- The certificates of insurance and any of their attachments.
- Any signed applications or written statements of the Policyholder or insured persons.

This Policy is issued in consideration of the application and the remittance of the premium. It is subject to the terms and conditions stated on the attached pages.

Termination will occur only if the Policyholder fails to pay the premiums. If this Policy is terminated, all insured persons will have a guaranteed right to elect converted coverage. The premiums under this Policy may be changed on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

This Policy does not replace Workers' or Workmen's Compensation insurance, or affect the requirements for coverage by Workers' or Workmen's Compensation insurance.

This Policy may not be changed unilaterally. An officer or a registrar of Unum and the Policyholder must approve changes. The approval must be in writing and endorsed on or attached to this Policy. No other person, including an agent, may change this Policy or waive any part of it. Any changes to this Policy must be offered to each person insured under this Policy at the time the change is made. The insured may accept or decline the offer.

Unum cannot contest or void a Policyholder's Policy in the first 2 years that the Policy is in force unless statements made by the Policyholder in the signed application are misrepresentations. However, the long term care insurance plan will end at any time if the Policyholder does not remit to Unum the required premiums for this insurance.

POLICYHOLDER AND UNUM OBLIGATIONS

The Policyholder must give Unum information at regular intervals about people:

- who become eligible to receive coverage,
- who change the amount of their coverage, or
- whose coverage ends.

Unum also will be allowed to look at any of the Policyholder's records that Unum believes have a bearing on this insurance. Unum may do this at any reasonable time.

If the information provided is inaccurate:

- Unum will use the corrected factual information to decide whether the person can receive coverage, and
- Unum will make a fair adjustment of the premium.

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

Unum will provide certificates to insured persons.

This Policy can be terminated by Unum or by the Policyholder.

Unum can terminate this Policy by written notice of at least 45 days if:

- fewer than 10 employees are covered by this Policy,
- the Policyholder does not promptly give Unum any information that Unum requires, or
- the Policyholder fails to perform any of its obligations that relate to this Policy.

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

The Policyholder must pay all of the premiums for the entire time that this 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 the benefits.

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

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

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

PREMIUM RATES

The initial premium charges will be figured at the premium rates as shown on the following pages. Unum may change the premium rates when the terms of this Policy are changed.

Any change in premium rates shall be made by written notice to the Policyholder, and insured persons who are direct billed by Unum, at least 45 days in advance of the change. Changes may take effect on an earlier date when both Unum and the Policyholder agree. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

No change in initial premium rates will become effective prior to January 1, 2008 unless the terms of the Policyholder's plan of insurance are changed.

PREMIUM DUE DATES

The first premium due date will be the Policy Effective Date. The Policyholder and insured persons who are direct billed by Unum must pay all premiums due under this Policy, including any adjustments, on or before the respective premium due dates shown on the face page of this Policy or on the direct bill. Premiums must be paid to Unum's Home Office in United States Dollars and sent to the address shown on the bill. For insured persons who are direct billed, if premium is not paid by the premium due date, Unum will send written notification to the insured person that coverage will terminate. This notification will not be given until thirty (30) days after a premium is due and unpaid. If the insured person has designated another person to receive notification of termination of insurance for nonpayment of premium, this notice will also be sent to him/her.

The premium due must be paid within the 65 day Grace Period after the premium due date. If premium is not paid within this time, coverage will automatically terminate at the end of the Grace Period.

PREMIUM ADJUSTMENTS

Premiums for additional, increased, or terminated insurance may cause a pro-rata adjustment on the next premium due date.

Adjustments for premiums will be made only for the current insurance year and the prior insurance year.

In the case of fraud, adjustments for premiums will be made for other insurance years as well.

Policy 113509-002
Initial Rates

Unum Long Term Care Plan

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	3 YEARS		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	$36,000		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
18	1.80	2.80	5.80	8.10
19	1.80	2.80	5.80	8.10
20	1.80	2.80	5.80	8.10
21	1.80	2.80	5.80	8.10
22	1.80	2.80	5.80	8.10
23	1.80	2.80	5.80	8.10
24	1.80	2.80	5.80	8.10
25	1.80	2.80	5.80	8.10
26	1.80	2.80	5.80	8.10
27	1.80	2.80	5.80	8.10
28	1.80	2.80	5.80	8.10
29	1.80	2.80	5.80	8.10
30	1.80	2.80	5.80	8.10
31	1.80	2.80	5.90	8.20
32	1.80	2.90	6.00	8.40
33	1.90	2.90	6.20	8.60
34	2.00	3.00	6.30	8.80
35	2.00	3.10	6.60	9.10
36	2.10	3.20	6.70	9.30
37	2.20	3.30	6.90	9.50
38	2.30	3.50	7.10	9.90
39	2.40	3.60	7.40	10.20
40	2.50	3.70	7.50	10.40
41	2.60	3.90	7.80	10.70
42	2.70	4.10	8.10	11.10
43	2.80	4.20	8.30	11.40
44	2.90	4.40	8.60	11.80
45	3.10	4.70	8.90	12.10
46	3.30	4.90	9.10	12.50
47	3.40	5.10	9.30	12.90
48	3.60	5.50	9.70	13.40
49	3.80	5.80	10.00	13.90
50	4.00	6.10	10.20	14.30
51	4.20	6.50	10.60	15.00
52	4.50	6.90	11.00	15.60
53	4.80	7.30	11.40	16.10
54	5.00	7.70	11.70	16.70
55	5.30	8.20	12.30	17.30
56	5.70	8.60	12.80	18.10
57	6.10	9.40	13.40	19.00

Policy 113509-002
Initial Rates

Unum Long Term Care Plan

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	3 YEARS		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	$36,000		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
58	6.50	10.00	14.10	19.80
59	7.00	10.80	14.70	20.70
60	7.60	11.60	15.50	21.80
61	8.30	12.50	16.60	23.20
62	9.10	13.70	17.90	24.90
63	10.00	14.80	19.10	26.40
64	11.00	16.10	20.60	28.30
65	12.50	18.00	22.90	31.00
66	13.80	19.60	24.80	33.10
67	15.40	21.40	27.00	35.70
68	17.10	23.40	29.20	38.10
69	18.90	25.50	31.70	40.90
70	20.90	27.80	34.10	43.60
71	23.30	30.50	37.30	47.20
72	25.80	33.40	40.60	50.80
73	28.70	36.70	44.00	54.70
74	31.70	40.10	47.70	58.90
75	38.20	47.80	56.40	69.00
76	41.90	52.00	61.20	74.20
77	46.00	56.50	65.90	79.20
78	50.50	61.50	71.30	85.00
79	55.40	66.90	76.60	90.90
80	60.90	72.80	83.00	97.70

Policy 113509-002
Initial Rates

Unum Long Term Care Plan

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	6 YEARS		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	$72,000		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
18	2.40	3.80	7.70	10.90
19	2.40	3.80	7.70	10.90
20	2.40	3.80	7.70	10.90
21	2.40	3.80	7.70	10.90
22	2.40	3.80	7.70	10.90
23	2.40	3.80	7.70	10.90
24	2.40	3.80	7.70	10.90
25	2.40	3.80	7.70	10.90
26	2.40	3.80	7.70	10.90
27	2.40	3.80	7.70	10.90
28	2.40	3.80	7.70	10.90
29	2.40	3.80	7.70	10.90
30	2.40	3.80	7.70	10.90
31	2.50	3.80	7.90	11.20
32	2.50	3.90	8.10	11.40
33	2.60	4.00	8.30	11.70
34	2.60	4.10	8.50	12.00
35	2.70	4.20	8.80	12.30
36	2.80	4.40	9.00	12.60
37	2.90	4.50	9.20	13.00
38	3.10	4.70	9.50	13.40
39	3.20	4.90	9.80	13.70
40	3.30	5.10	10.10	14.10
41	3.40	5.30	10.30	14.50
42	3.60	5.50	10.70	15.00
43	3.80	5.80	11.00	15.40
44	4.00	6.00	11.40	15.90
45	4.20	6.40	11.70	16.40
46	4.40	6.70	12.10	17.00
47	4.60	7.10	12.40	17.50
48	4.90	7.50	12.80	18.10
49	5.00	7.90	13.20	18.80
50	5.30	8.30	13.50	19.40
51	5.60	8.80	14.00	20.10
52	5.90	9.40	14.50	20.90
53	6.30	10.00	15.00	21.80
54	6.60	10.60	15.50	22.60
55	7.10	11.30	16.10	23.30
56	7.50	12.00	16.80	24.30
57	8.00	12.90	17.50	25.50

Policy 113509-002
Initial Rates

Unum Long Term Care Plan

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	6 YEARS		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	$72,000		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
58	8.60	13.80	18.40	26.80
59	9.20	14.80	19.20	28.00
60	9.90	15.80	20.10	29.40
61	10.90	17.20	21.60	31.50
62	11.90	18.70	23.30	33.80
63	13.00	20.40	24.80	35.90
64	14.30	22.20	26.60	38.40
65	16.20	24.80	29.50	42.20
66	17.90	27.10	32.00	45.20
67	19.90	29.60	34.80	48.70
68	22.00	32.30	37.50	52.00
69	24.30	35.20	40.50	55.80
70	26.90	38.50	43.60	59.60
71	29.90	42.30	47.70	64.60
72	33.10	46.30	51.80	69.60
73	36.50	50.70	55.90	74.90
74	40.40	55.50	60.70	80.60
75	48.60	66.20	71.60	94.40
76	53.40	72.00	77.60	101.70
77	58.50	78.40	83.50	108.70
78	64.20	85.30	90.20	116.50
79	70.30	92.80	96.90	124.80
80	77.10	100.90	104.80	134.10

Policy 113509-002 Unum Long Term Care Plan
Initial Rates

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	UNLIMITED		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	UNLIMITED		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
18	3.30	5.40	10.30	15.20
19	3.30	5.40	10.30	15.20
20	3.30	5.40	10.30	15.20
21	3.30	5.40	10.30	15.20
22	3.30	5.40	10.30	15.20
23	3.30	5.40	10.30	15.20
24	3.30	5.40	10.30	15.20
25	3.30	5.40	10.30	15.20
26	3.30	5.40	10.30	15.20
27	3.30	5.40	10.30	15.20
28	3.30	5.40	10.30	15.20
29	3.30	5.40	10.30	15.20
30	3.30	5.40	10.30	15.20
31	3.30	5.40	10.50	15.50
32	3.50	5.60	10.80	15.90
33	3.50	5.70	11.10	16.30
34	3.60	5.80	11.30	16.50
35	3.70	6.00	11.60	17.00
36	3.80	6.10	11.90	17.40
37	4.00	6.40	12.30	17.90
38	4.10	6.60	12.60	18.30
39	4.30	6.80	13.00	18.90
40	4.40	7.10	13.30	19.40
41	4.70	7.40	13.70	20.00
42	4.80	7.70	14.10	20.60
43	5.10	8.10	14.50	21.10
44	5.30	8.40	15.00	21.80
45	5.60	8.90	15.40	22.40
46	5.90	9.30	15.90	23.20
47	6.10	9.90	16.30	24.00
48	6.40	10.40	16.90	24.90
49	6.70	11.00	17.20	25.70
50	7.10	11.70	17.80	26.70
51	7.60	12.40	18.30	27.70
52	7.90	13.10	18.90	28.80
53	8.30	14.00	19.60	30.00
54	8.80	14.80	20.20	31.10
55	9.20	15.60	20.80	31.90
56	9.80	16.80	21.70	33.30
57	10.50	17.90	22.70	35.00

Policy 113509-002
Initial Rates

Unum Long Term Care Plan

BASE PLAN:		OPTIONS:	
FACILITY MONTHLY BENEFIT	$1000	HOME CARE LEVEL	TOTAL
HOME MONTHLY BENEFIT	$500	INFLATION PROTECTION	COMPOUND
FACILITY BEN DURATION	UNLIMITED		
HOME BENEFIT	50%		
LIFETIME MAXIMUM	UNLIMITED		
ELIMINATION PERIOD	90 DAYS		
HOME CARE LEVEL	PROFESSIONAL		

MONTHLY RATES

INSURANCE AGE	BASE PLAN	BASE PLAN WITH TOTAL HOME CARE OPTION	BASE PLAN WITH COMPOUND INFLATION OPTION	BASE PLAN WITH TOTAL HOME CARE COMPOUND INFLATION OPTIONS
58	11.20	19.20	23.60	36.70
59	12.00	20.60	24.70	38.50
60	12.80	22.10	25.80	40.40
61	14.00	24.00	27.60	43.20
62	15.30	26.20	29.50	46.30
63	16.70	28.50	31.40	49.20
64	18.20	31.00	33.50	52.60
65	20.50	34.60	37.10	57.80
66	22.80	37.80	40.20	62.00
67	25.20	41.30	43.60	66.80
68	27.80	45.10	47.00	71.30
69	30.70	49.10	50.80	76.50
70	34.00	53.60	54.70	81.90
71	37.70	58.70	59.60	88.50
72	41.60	64.10	64.70	95.20
73	45.80	70.00	69.70	102.20
74	50.40	76.30	75.40	109.60
75	60.50	90.80	88.70	128.10
76	66.50	98.80	96.20	137.90
77	72.90	107.40	103.50	147.30
78	79.70	116.70	111.60	157.80
79	87.20	126.70	119.70	168.70
80	95.40	137.50	129.30	181.00

Unum Life Insurance Company of America

AMENDMENT

This amendment forms a part of the Group Policy issued to the Policyholder.

1. If an employee is on a family or medical leave of absence, Unum will continue coverage under the Policy -- in accordance with the employer's Human Resource policy on family and medical leaves of absence -- as if the employee were in active employment, if the following conditions are met:

   a. premiums are paid in accordance with the Policy provisions, and

   b. the employer has approved the employee's leave in writing.

2. Coverage will be continued for up to the greater of:

   a. the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments;

   b. the leave period required by applicable state law; or

   c. the leave period provided in the Policy for the employee's medical leave for sickness or injury.

3. If coverage is not continued during a family or medical leave of absence, upon the employee's return to active employment:

   a. no new waiting periods will be applied,

   b. no new pre-existing conditions exclusions or limitations will be applied, and

   c. no evidence of insurability will be required,

   to reinstate the coverage in effect on the date before the leave began.

4. If the Policy contains a pre-existing conditions exclusion or limitation provision, the time period in the provision will continue to run through an insured's family or medical leave of absence.

5. If the Policy contains a "Temporary Layoff and Leave of Absence Provision", this provision applies only to leaves other than family and medical leaves of absence.

The effective date of this amendment is August 5, 1993 or the effective date of the Policy, if later.

Signed for the Company at Portland, Maine

Registrar

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. The Policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Policy Number: 113509 002

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: This Certificate is guaranteed renewable on each Policy Anniversary as long as the Policyholder continues to remit all premiums due within the Grace Period. Termination will occur only if the Policyholder fails to pay the premiums. If the Policy is terminated, all insured persons will have a guaranteed right to elect Continuation of Coverage. The premiums under the Policy may be changed on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

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 TO YOU WITHIN 30 DAYS AFTER RECEIPT OF YOUR WITHDRAWAL.

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.

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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. IN ADDITION, IF THIS CERTIFICATE PROVIDES OPTIONAL INFLATION PROTECTION AND YOU DO NOT CHOOSE IT, YOU ARE ADVISED THAT, BASED ON CURRENT HEALTH CARE COST TRENDS, YOUR BENEFITS MAY BE SIGNIFICANTLY DIMINISHED IN TERMS OF REAL VALUE, DEPENDING ON THE AMOUNT OF TIME WHICH ELAPSES BETWEEN THE DATE OF PURCHASE AND THE DATE UPON WHICH YOU FIRST BECOME ELIGIBLE FOR THOSE BENEFITS.

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 CP&Y, Inc. and its covered divisions, subsidiaries, and affiliated companies.

President

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unum's toll-free telephone number for information or to make a complaint at:

1-800-321-3889
OPTION NUMBER 2

You may also write to Unum at:

Deborah J. Jewett, Manager
Customer Relations
Unum Life Insurance Company
of America
2211 Congress Street
Portland, Maine 04122

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

1-800-252-3439

You may also write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007

Web: www.tdi.texas.gov

E-Mail: ConsumerProtection(a)
tdi.texas.gov

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(TDI).

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Unum's para obtener informacion o para presentar una queja al:

1-800-321-3889
OPCION NUMERO 2

Usted tambien puede escribir a Unum:

Deborah J. Jewett
Gerente de Relaciones al Cliente
Unum Life Insurance Company
of America
2211 Congress Street
Portland, Maine 04122

Usted puede communicarse con el Departamento de Seguros de Texas para obtener informacion sobre de companias, cobertura, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 490-1007

Web: www.tdi.texas.gov

E-Mail: ConsumerProtection(a)
tdi.texas.gov

DISPUTAS POR PRIMAS DE DE SUGUROS O RECLAMACIONES:

Si tiene una disputa relacionado con su prima de seguro con una reclamacion, usted debe comunicarse con la compania primero. Si la disputa no es resuelta, puede comunicarse con el Departamento de Seguros de Texas(TDI).

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SUMMARY OF BENEFITS

	Available March 1, 2003 Active Employees and Family Members At your expense
Monthly Benefit Maximum	
Long Term Care (LTC) Facility	$2,000 to $8,000 in $1,000 increments
Assisted Living Facility	60% of the LTC Facility amount
Professional Home Care Services	50% of the LTC Facility amount **OR**
Total Home Care	50% of the LTC Facility amount
Uncapped Compound Inflation Protection	5% compounded annually
Lifetime Maximum Amount	36X the LTC Facility amount **OR** 72X the LTC Facility amount **OR** Unlimited
Elimination Period	90 consecutive days

Evidence of Insurability Limits

If you choose any of the following benefits, you will be required to complete an Application for Long Term Care Insurance, which includes Evidence of Insurability:

- Monthly Benefit Maximum Amount(s) greater than $6,000; and
- an "Unlimited" Lifetime Maximum Amount.

These amounts are known as Evidence of Insurability Limits.

If you apply for benefits that exceed the Evidence of Insurability Limits and are approved, the "PRE-EXISTING CONDITIONS LIMITATION" will be waived for your entire amount(s) of insurance. If Unum disapproves your Application for Long Term Care Insurance, you will be insured for the amount(s) selected up to the amount that does not exceed the Evidence of Insurability Limit(s). The "PRE-EXISTING CONDITIONS LIMITATION" will apply.

"Unlimited" Lifetime Maximum Benefit Amount means your Maximum Benefit Amount will not be limited to any dollar amount.

CHANGES IN COVERAGE

For an Active Employee and the spouse of an Active Employee

You can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the later of:

- the first of the month after Unum approves your application, if approval is between the first and the fifteenth of the month; or
- the first of the second month after Unum approves your application, if approval is between the sixteenth and the end of the month.

The premium rate to be paid for any change 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 change in coverage.

For all other insured persons

You can apply at any time to change coverage by filling out a new Benefit Election Form and Application for Long Term Care Insurance. Changes in coverage will take effect at 12:01 a.m. on the first of the month after Unum approves your application.

The premium rate to be paid for any change 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 change in coverage.

WHEN CHANGES IN COVERAGE WILL BE DELAYED

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.

TERMS YOU SHOULD KNOW

When you see these words, here's what Unum means:

"**Active Employee**" means an employee working for the Policyholder:

- on a full-time basis for earnings that are paid regularly;
- for a minimum of 20 hours per week; and
- at the Policyholder's usual place of business or at a location to which their job requires them to travel.

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

- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the task 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 or out of a bed, chair, or wheelchair or to move from one location to another, indoors and outdoors, either via a walker, a wheelchair or other means.
- CONTINENCE - the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"**Adult Day Care**" means a social and health-related services program provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly, or other Disabled adults who can benefit from care in a group setting outside the home.

"**Adult Day Care Facility**" means a facility which operates pursuant to federal and state law, and provides Adult Day Care on a daily or regular basis, but not overnight, to adults who are not related by blood, marriage, or adoption to the owner of the facility.

"**Assisted Living Facility**" means an institution that operates pursuant to state and federal law or a similar facility approved by Unum.

An Assisted Living Facility **does not** include:

- any home, facility, or part thereof used primarily for rest; or
- a home or facility for the aged or for the care of drug addicts or alcoholics; or
- a home or facility primarily used for the care and treatment of mental diseases or disorders; or
- a home or facility used for custodial or educational care.

"**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.

"**Elimination Period**" means the number of consecutive days during which you must be Disabled and under the regular care of a Physician before benefits become payable.

If your plan includes Professional Home Care Services, each calendar week that you receive at least one day of these services will be counted as seven days towards completing the Elimination Period. However, if you do not receive these services for at least one day within a calendar week, the Elimination Period will begin again.

"**Family Members**" means:

- the legally married spouse of an Active Employee;
- the natural, adoptive or step-parents/grandparents of an Active Employee and their spouse;
- the natural, adoptive or step-siblings of an Active Employee and their spouse;
- the natural, adoptive or step-children of an Active Employee and their spouse.

Family Members who are eligible for coverage as an Active Employee are only eligible for coverage as an employee.

To be eligible for coverage, Family Members must be between the ages of 18 and 80.

"**Grace Period**" means the 65 days immediately following any premium due date during which premium payment must be made.

"**Home Health Care Agency**" means a business which provides home health care services and is licensed by the Texas Department of Health. Home health care services are medical or nonmedical services provided to ill, Disabled or infirm persons in their residences. Such services may include homemaker services, assistance with Activities of Daily Living, respite care services, case management services and maintenance of personal care services.

"**Hospice Care**" means a formal program of care for terminally ill patients whose life expectancy is less than 6 months, provided on an inpatient basis and directed by a Physician in a Hospice Care Facility that is licensed, certified or registered in accordance with state law.

"**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.

"**Lifetime Maximum Amount**" means the maximum Unum will pay you for all long term care benefits. You have your own Lifetime Maximum Amount.

"**Long Term Care Facility**" means an institution that operates pursuant to state and federal law. However, Unum may approve a similar institution if such institution is not required to be licensed.

A Long Term Care Facility **does not** include:

- any home, facility, or part thereof used primarily for rest; or
- a home or facility for the aged or for the care of drug addicts or alcoholics; or
- a home or facility primarily used for the care and treatment of mental diseases or disorders; or
- a home or facility used for custodial or educational care.

"**Physician**" means a person 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 Unum for long term care insurance:

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

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

- received or were recommended medical advice or 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.

"**Professional Home Care Services**" means:

- visits to your residence by a Home Health Care Agency to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services. Each one hour or more per day of a Home Health Care Agency's services will be considered one visit;
- Adult Day Care; or
- Hospice Care.

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

Professional Home Care Services do not include services performed by your spouse, daughter, son, parent, sister, brother, grandparent or grandchild through a Home Health Care Agency or an Adult Day Care Facility.

"Severe Cognitive Impairment" means a deterioration or loss in intellectual capacity, requiring Substantial Supervision by another individual for the purpose of protecting you from harming yourself or others, as measured by clinical diagnosis by a Physician authorized to make such a diagnosis. The diagnosis will include your:

- medical history;
- physical, neurological, psychological and/or psychiatric evaluations; and
- laboratory findings.

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.

"Total Home Care" means:

- visits to your residence by a Home Health Care Agency to provide skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services;
- Adult Day Care;
- Hospice Care; or
- care provided by an informal caregiver, such as a friend or relative.

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

BENEFIT INFORMATION

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You are eligible for a Monthly Benefit if, after the effective date of your coverage and while your coverage is in effect,:

- you suffer the loss of 2 or more ADLs; or
- you suffer Severe Cognitive Impairment; and
- you 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 Service Benefit);(or Total Home Care if your plan includes a Total Home Care Benefit);
- you have satisfied your Elimination Period; and
- a Licensed Health Care Practitioner has certified that you are unable to perform (without Substantial Assistance from another individual) two 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 Licensed Health Care Practitioner certification every 12 months.

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

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

AMOUNT OF MONTHLY BENEFIT

The amount of your monthly benefit will be based on the coverage options you chose from the SUMMARY OF BENEFITS and the place of residence used for long term care. See your SCHEDULE OF LONG TERM CARE BENEFITS form to determine the amount we will pay you each month.

If your plan includes Professional Home Care Services, the benefit payment will be based on the number of days you receive these services each month.

A monthly benefit payable for less than one month will be paid at the rate of 1/30th of the monthly benefit amount for each day you are eligible for a monthly benefit.

WHEN MONTHLY BENEFITS ARE PAID

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 days you were eligible to receive benefits during the prior month. However, if you die during a period in which payment is due, payment may be made to the executor or administrator of your estate.

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 Licensed Health Care Practitioner 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.

WAIVER OF PREMIUM

Once benefits become payable, there will be no more cost for your coverage as long as you are Disabled. If you do not receive Professional Home Care Services for a period of 30 consecutive days, premium payments will again become due. If benefits are no longer payable, you must resume premium payments to continue your coverage. Premiums are **not waived** while you are receiving a payment for Respite Care.

RECURRENT DISABILITY

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

RESPITE CARE BENEFITS

If you are eligible for a home care benefit but are not yet receiving monthly payments because you:

- have not yet completed the Elimination Period; or
- have completed the Elimination Period but have chosen to postpone receipt of benefits in order to preserve your Lifetime Maximum Amount

we will pay a benefit equal to 1/30th of your home care benefit for each day that you receive Respite Care up to a maximum of 15 days per calendar year.

Payments made to you for Respite Care will reduce your Lifetime Maximum Amount.

Respite Care may be provided to you by:

- a formal caregiver, such as a Home Health Care Agency, an Adult Day Care Facility, a registered nurse, a licensed practical nurse, etc., or
- an informal caregiver such as your friends or relatives.

BED RESERVATION BENEFIT

If you are receiving a Long Term Care Facility or Assisted Living Facility 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 Elimination Period, such days will be used to help satisfy this period.

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

INFLATION PROTECTION

Uncapped Compound Growth Inflation Protection Option

If you have chosen this option, your Monthly Benefit will increase each year on January 1st by 5% of the Monthly Benefit in effect on that date. As long as your coverage remains in effect, inflation increases will occur automatically for your Monthly Benefit Amount and Lifetime Maximum Amount as shown in the SUMMARY of BENEFITS, regardless of your health or whether or not you are Disabled. Your premium will not increase due to automatic increases in these amounts.

An example of a 5% uncapped compound growth inflation protection increase is:

An LTC Facility Monthly Benefit amount of $1,000 will be increased:
1. by 5% to $1,050 on January 1st of the next calendar year;
2. by 5% of $1,050 to $1,102.50 on the next January 1st; and
3. by 5% of the previous benefit amount on each following January 1st.

CONTINGENT NONFORFEITURE BENEFIT

If your premium rates increase to a level which results in a cumulative increase of your annual premium equal to or exceeding the percentage of your initial annual premium shown in the chart below, based on issue age, you may choose to do one of the following:

1. continue to pay the required premium;
2. decrease your coverage, without additional underwriting, so that premium payments are not increased;
3. elect to convert your coverage within 120 days of the premium increase effective date to a paid-up status with the Contingent Nonforfeiture Benefit; or
4. terminate your coverage within 120 days of the premium increase effective date and be automatically converted to the Contingent Nonforfeiture Benefit.

The percentage increase in premium does not include increases to premium due to changes to your Long Term Care insurance coverage.

If you stop making premium payments under items 3 and 4, this means that your coverage will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Amount. Your Lifetime Maximum Amount under this Contingent Nonforfeiture Benefit will be equal to the total premium paid up to the date you stopped paying premiums.

In no event will your Lifetime Maximum Amount:

- be less than one Long Term Care Facility Monthly Benefit payment amount; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains an inflation protection benefit and continues under the Contingent Nonforfeiture Benefit, no inflation protection increases will be made after the end of the period for which premiums were last remitted to Unum for your coverage.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 & Under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

PLAN EXCLUSIONS

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

- a Disability caused by war (whether declared or not) or any act of war,
- a Disability caused by attempted suicide (while sane or insane) or intentional self-destruction,
- a Disability caused by a 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 alcoholism or alcohol abuse,
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- 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:
  - neurosis,
  - psychoneurosis,
  - psychopathy,
  - psychosis, or
  - mental or emotional disease or disorder of any kind

  whether treated by drugs, counseling or other forms of therapy.

  However, Unum will make payments to you for conditions that are not mental or nervous in nature, including Alzheimer's disease, biologically-based brain diseases and serious mental illness including:

  - schizophrenia,
  - paranoid and other psychotic disorders,
  - bipolar disorders (mixed, manic and depressive),
  - major depressive disorders (single episode or recurrent) and
  - schizo-affective disorders (bipolar or depressive).

PRE-EXISTING CONDITIONS LIMITATION

A Pre-Existing Condition is any condition that exists for which you:

- received or were recommended medical advice or 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 monthly benefit payments to you during the first six months after your coverage begins if your eligibility for the monthly benefit is based on Severe Cognitive Impairment or the loss of an ADL that:

- is caused by, contributed to by, or results from a Pre-Existing Condition, and
- is present during the first six months after your coverage begins.

This Pre-Existing Conditions limitation will apply to all insurance that does not require evidence of insurability.

REHABILITATION AND ALTERNATE CARE PLANS

While you are Disabled, we may suggest special services and /or equipment designed to help you regain the ability to independently perform the Activities of Daily Living. The services and/or equipment must be medically necessary and appropriate for your Disability and provided pursuant to a written plan of care developed by a Licensed Health Care Practitioner. The services or equipment must be intended to assist you in living at home or other residential housing by eliminating your need for Substantial Assistance. The services or equipment cannot be covered by other insurance or Medicare. Examples of Alternate Care Plans may include, but are not limited to:

- a rehabilitation program;
- home modifications for wheelchair access; and
- certain types of medical equipment, emergency medical response systems or hardware purchases.

The terms of an Alternate Care Plan and the actual expenses that Unum will pay will be subject to written mutual agreement between Unum, you and your Physician.

If, for any reason, you do not wish to participate in an Alternate Care Plan, your benefits will continue according to the provisions of the Policy.

CLAIM INFORMATION

NOTICE OF CLAIM

You must give us written notice of claim within thirty (30) days of the date you become Disabled. If it is not possible for you to give us 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 date you become Disabled. 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, unless you are legally incapacitated.

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 Licensed Health Care Practitioner 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 written plan of care developed by a Licensed Health Care Practitioner;
- 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 possible. However, proof of continued Disability must be given no later than one year after the time proof is otherwise requested, unless you are legally incapacitated.

Claims for a Professional Home Care Services monthly benefit must also include proof of the number of days these services were provided to you.

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.

Benefits payable under the Policy become payable within 60 days after the receipt of proof of claim.

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.

CLAIM DENIAL

If your claim is denied, we shall make available all information directly related to such denial within 60 days of the date of your written request, unless such disclosure is prohibited under state or federal laws.

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 payments equal your Lifetime Maximum Amount; or
- the date the Policy ends; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you are no longer an Active Employee with the Policyholder; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you no longer work for the Policyholder; or
- the end of the period for which premiums were last paid to Unum for your coverage following the date you request to terminate 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

You may elect to continue the same coverage you had under the group policy on a direct billing basis, if your group coverage ends. **You may not elect to continue coverage if you are not insured under the group policy. You may not elect to continue coverage if your group coverage ended because:**

- **you failed to make any required premium payment when due; or**
- **you failed to make any contribution when due.**

Election for continued coverage must be made within 31 days from:

- the date your group coverage ends; or
- the date the group policy terminates.

Your continued coverage will be on a direct billing basis, if your premium is payroll deducted. Your continued coverage:

- will be maintained under the existing group policy, if your coverage terminated because you are no longer eligible for coverage; or
- will be continued under a continuation group policy, if the existing group policy terminates.

If you are already direct billed, your coverage will automatically continue:

- under the existing group policy, if you are no longer eligible for coverage; or
- under a group continuation policy, if the existing group policy terminates.

Your continued coverage will remain in force, as long as you continue timely payment of premium when due. You must pay premium directly to Unum for continued coverage.

The premium rate schedule for continued 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 continued your coverage, you can apply at any time to change your continued coverage. To change your coverage, you must contact Unum's home office. You will need to complete the necessary forms, which may include evidence of insurability.

GENERAL INFORMATION

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 two (2) years, Unum may rescind your coverage or deny an otherwise valid long term care insurance claim upon a showing of misrepresentation, or an intent to deceive by you in your application for insurance.

After a certificate has been in force for two (2) years, such certificate may be contested only upon a showing that you knowingly and intentionally provided fraudulent information relevant to facts relating to your health, or for nonpayment of premium.

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 by the premium due date or within the 65 day Grace Period. If premium is not paid within this time, your coverage will terminate.

If premium is not paid by the premium due date, you will receive written notification from Unum that your coverage will terminate. This notification will not be given until thirty (30) days after a premium is due and unpaid. If you have designated another person to receive notification of termination of insurance for nonpayment of premium, this notice will also be sent to him/her.

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 65 day 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;
- we must approve that reinstatement application; and
- you must pay all unpaid premium.

If we approve the reinstatement application, we will reinstate your coverage on the approval date. If we issue a prepayment agreement and do not approve or disapprove the reinstatement application within 45 days from the date of the prepayment agreement, we will reinstate your coverage on that 45th day.

If the Policy is reinstated, it will only cover losses incurred on or after the date the policy is reinstated. In all other respects, upon reinstatement, all of the provisions under the Policy immediately before the due date of the defaulted premium will resume.

The reinstatement 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 65 day 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.

If you meet these requirements, we will reinstate your coverage on the coverage termination date.

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

POLICY RENEWABILITY

The Policy is guaranteed renewable on each Policy Anniversary as long as the Policyholder continues to remit all premiums due within the Grace Period. Termination will occur only if the Policyholder fails to pay the premiums. If your coverage is ended by the Policyholder, all insured persons will have a guaranteed right to elect continuation of coverage. However, the right to elect continuation of coverage does not apply if your coverage ends because you stopped paying premiums.

The premiums under the Policy may be changed on a class basis according to Unum's underwriting risk studies under this type of insurance coverage.

FEDERAL INCOME TAX TREATMENT OF THE POLICY

The Health Insurance Portability and Accountability Act of 1996 granted favorable federal income tax treatment of qualified long term care policies. To the best of our knowledge, the Policy was designed to meet the requirements of this new law. If, in the future, it is determined that the Policy does not meet these requirements, we will make every reasonable effort to amend the Policy in order to gain such favorable federal income tax treatment. Such amendment must be filed and approved by the appropriate insurance department prior to issuance. You will be offered the opportunity to receive these amendments.

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:
CP&Y, Inc. Plan

Name and Address of Employer:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235

Plan Identification Number:
a. Employer IRS Identification #: 75-1720414
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.:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235
(214)640-1703

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

Agent for Service of Legal Process on the Plan:
CP&Y, Inc.
1820 Regal Row
Suite 200
Dallas, Texas 75235

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 113509 002. 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:

- fewer than 10 employees insured under a Plan; or
- 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.