Crosspoint Inc

Your Group Long Term Care Insurance Plan

Policy No. 557415

Underwritten by Unum Life Insurance Company of America

07-2018

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: 557415

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 converted 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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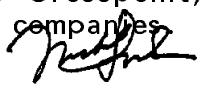
NOTICE TO BUYER: THIS CERTIFICATE MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH LONG TERM CARE INCURRED BY YOU DURING THE PERIOD OF COVERAGE. YOU ARE ADVISED TO REVIEW CAREFULLY ALL COVERAGE LIMITATIONS. IN ADDITION, IF THIS CERTIFICATE PROVIDES OPTIONAL INFLATION PROTECTION AND YOU DO NOT CHOOSE IT, 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 Crosspoint, 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, coberturas, 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 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 Suguros de Texas (TDI).

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SUMMARY OF BENEFITS

Elimination Period- 90 consecutive days

BASE COVERAGE

Monthly Benefit Maximum *

Long Term Care Facility	Assisted Living Facility
$1,000 to $6,000 in $1,000 increments	60% of the Long Term Care Facility Monthly Benefit

ADDITIONAL COVERAGE OPTIONS

Monthly Benefit Maximum *

Professional Home Care Services
50% of the Long Term Care Facility Monthly Benefit

Uncapped Compound Growth Inflation Protection
5% compounded annually

For example:

A 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.

As long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you are Disabled.

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

Lifetime Maximum Amount ** - (Applies to all Long Term Care benefits)

36 X the "Long Term Care Facility" amount.	72 X the "Long Term Care Facility" amount.	Unlimited

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

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 $4,000; 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.

DISCRETIONARY AUTHORITY

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

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 30 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.

If your plan does not include Professional Home Care Services, the entire Elimination Period must be completed while residing in a Long Term Care Facility or an Assisted Living Facility.

"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 an organization which provides home health care services and is licensed by the Texas Department of Health under Texas Civil Statutes, Article 4447u. Home health care 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.

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 Physician 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 Physician 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 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.

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 latest of these dates:

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

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

EXTENSION OF BENEFITS

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

CONVERSION

If group coverage ends for reasons other than your choice to have premium payments stopped for your coverage, you may elect a "converted policy". A "converted policy" means an individual long term care policy providing benefits identical to or benefits substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Evidence of insurability is not required if you elect to convert your coverage.

Election for converted coverage must be made within 60 days of the date the group coverage ends. You must pay premium directly to Unum for any converted coverage to be continued.

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

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

STATEMENTS

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

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

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

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

INCONTESTABILITY

For a certificate that has been in force for less than 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.

IMPORTANT INFORMATION FOR CONNECTICUT RESIDENTS

ENDORSEMENT TO CERTIFICATE OF INSURANCE

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

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

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

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

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

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

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

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

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

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

You are eligible for a Monthly Benefit after:

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

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

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

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

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

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

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

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

ADDITIONAL CLAIM AND APPEAL INFORMATION

APPLICABILITY OF ERISA

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. Whether a Plan is governed by ERISA is determined by a court, however, your employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Policy, including your Certificate of Coverage, and any additional summary plan description information provided by the Plan Adminstrator. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information in this document.

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.