Overlake Hospital Medical Center

Your Group Long Term Care Plan

Policy No. 148524 011

Underwritten by Unum Life Insurance Company of America

10/15/2020

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
(207) 575-2211

LONG TERM CARE INSURANCE CERTIFICATE OF COVERAGE

This Certificate of Coverage is part of the entire policy. This Certificate is subject to the terms and conditions stated on the attached pages, all of which terms and conditions are part of the policy. The policy determines governing contractual provisions and is available for viewing at the Policyholder's office and will be copied for you upon request at no cost. This Certificate is evidence of your coverage under the policy. It describes the benefits, coverage, exclusions and limitations of the policy that principally affect you. This Certificate is of value to you. Please keep it in a safe place.

IMPORTANT INFORMATION ABOUT YOUR APPLICATION

If you were required to complete a Long Term Care Insurance Application in connection with your request to obtain coverage, the issuance of this Certificate is based upon your responses to the questions on your application and any medical exam, tests or other questionnaires, including a face-to-face assessment. A copy of your Long Term Care Insurance Application was retained by you when you applied. **If your responses are incorrect or untrue, we 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 us at the address listed below.

NOTICE TO BUYER

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance For People with Medicare available from us.

We are not representing Medicare, the federal government or any state government.

30 DAY RIGHT TO EXAMINE YOUR CERTIFICATE

You may cancel this Certificate for any reason within 30 days after it is delivered to you or your representative. Simply return this Certificate, within 30 days of its receipt, to the Policyholder's plan administrator or Unum. If this is done, this Certificate will be canceled from the beginning, and all of the premium paid will be refunded. A 10% penalty will be added to any premium refund due which is not paid within 30 days of return of the policy.

GUARANTEED RENEWABLE

Your coverage is Guaranteed Renewable. This means that you have the right to continue your long term care insurance coverage in force as long as premium for your coverage is paid when it is due. However, we reserve the right to change any or all premiums. Any change in premium must apply to all similar policies issued, on this policy form, in the state in which the policy is sitused, including policies with different form numbers. Premiums cannot be increased because of any change in the age or health of the persons covered under the policy. We cannot discontinue your coverage except where required by law or as a result of nonpayment of premium. 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 60 days in advance of the change.

EMPLOYEE RETIREMENT INCOME SECURITY ACT

The policy is governed, to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

EFFECTIVE DATE

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Underwritten by
Unum Life Insurance Company of America

Mailing Address
2211 Congress Street, Portland, Maine, 04122

Secretary

President

TABLE OF CONTENTS

BENEFITS AT A GLANCE
Long Term Care Insurance

This long term care plan pays benefits if you suffer a Chronic Illness.

POLICYHOLDER: Overlake Hospital Medical Center

POLICYHOLDER'S ORIGINAL PLAN EFFECTIVE DATE: July 1, 2010

POLICY NUMBER: 148524 011

ELIGIBLE GROUP(S):

Physicians and their Family Members, including Domestic Partners

Employees must be in Active Employment with the Policyholder.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 48 hours per semi-monthly pay period.

WAITING PERIOD:

For Employees in an Eligible Group on or before July 1, 2010: None

For Employees entering an Eligible Group after July 1, 2010: First of the month coincident with or next following 1 month of continuous active employment

REHIRE:

If your employment ends and you are rehired within 12 months, your prior period of work while in an Eligible Group will apply toward the Waiting Period. All other policy provisions apply.

POLICYHOLDER PAID COVERAGE FOR EMPLOYEES:

The Policyholder pays for the following coverage for Employees. Employees can choose higher levels of coverage by paying the additional cost.

LTC Facility Monthly Benefit - $2,000
Benefit Duration - 3 years
Professional Home and Community Care - 50% of the LTC Facility Monthly Benefit
Accelerated Payment Option - 10 Years

LTC FACILITY MONTHLY BENEFIT:

For eligible Employees:

$2,000 - $9,000 per month in $1,000 increments

For all other eligible persons:

$2,000 - $9,000 per month in $1,000 increments

BENEFIT DURATION:

Choice A

3 years

Choice B
6 years

Choice C
Lifetime

HOME CARE BENEFIT:

You may choose either Professional Home and Community Care or Total Choice Home Care, but not both.

Professional Home and Community Care

50% of the LTC Facility Monthly Benefit

Total Choice Home Care

50% of the LTC Facility Monthly Benefit

ADDITIONAL BENEFITS:

Each of the following benefit(s) is optional:

Accelerated Payment Option - 10 Years
Inflation Protection - 5% Compound

If the benefit is shown under POLICYHOLDER PAID COVERAGE FOR EMPLOYEES above, that benefit is automatically included for the Employee.

ELIMINATION PERIOD:

90 accumulated days. The Elimination Period must be satisfied within a period of 730 consecutive days. Benefits begin the day after the Elimination Period is completed.

WHO PAYS FOR THE COVERAGE:

For eligible Employees:

You and the Policyholder pay the cost of your coverage.

For all other eligible persons:

You pay the cost of your coverage.

EVIDENCE OF INSURABILITY LIMITS:

For eligible Employees:

Evidence of Insurability will be required if you apply:
- for a monthly benefit greater than $6,000; or
- for a Lifetime Benefit Duration; or
- more than 31 days after you were eligible for coverage.

After the initial enrollment period, you can apply for coverage with evidence of insurability by filling out the benefit election form and the Long Term Care Insurance Application. These forms can be obtained from the Policyholder.

For all other eligible persons:

You must always submit a Long Term Care Application and provide, at your own expense, Evidence of Insurability satisfactory to us.

WAIVER OF PREMIUM:

No premium payments are required for your coverage while you are receiving monthly benefit payments under this policy.

ADDITIONAL CARE BENEFIT:

Once you are eligible for a benefit payment, you will have access to Additional Care Benefits designed to assist you in living at home or in other residential housing, other than a LTC Facility. You do not need to complete the Elimination Period for an Additional Care Benefit payment to begin.

THE ADDITIONAL CARE LIFETIME MAXIMUM BENEFIT AMOUNT: $5,000. This is in addition to your Lifetime Maximum Benefit.

OTHER FEATURES:

Bed Reservation
Respite Care
Contingent Non-Forfeiture
Continuation of Coverage

This is not intended to be a complete description of the Long Term Care policy. This policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage, refer to your Certificate of Coverage.

THE CERTIFICATE OF COVERAGE

This Certificate is a written statement prepared by Unum and may include attachments. It tells you:
- the coverage to which you may be entitled;
- to whom Unum will make a payment;
- the limitations, exclusions and requirements that apply within a plan.

ELIGIBILITY FOR COVERAGE

Employee

If you are working for the Policyholder in an Eligible Group, the date you are eligible for coverage is the later of:
- the Policy Effective Date; or
- the day after you complete your Waiting Period.

Eligible Family Members

If you are an Eligible Family Member, you will be eligible to apply for coverage on the later of:
- the Policy Effective Date; or
- the date the Employee is eligible to apply for coverage.

Although you may be eligible for coverage, your coverage will not begin until the date shown on your **Schedule of Benefits**, subject to the timely payment of premium for your coverage.

APPLICATION AND ENROLLMENT FOR COVERAGE

Employee

During your initial enrollment period, you can enroll for coverage without completing a Long Term Care Insurance Application for amounts that do not exceed the Evidence of Insurability limits as shown in the **Benefits at a Glance**. Simply complete a benefit election form. You can obtain a benefit election form from the Policyholder's plan administrator.

If the Policyholder pays the full amount of premium for your coverage, you do not need to enroll for coverage. However, you may need to enroll for coverage, by completing a benefit election form, when you pay all or a portion of the premium.

If you enroll for coverage after your initial enrollment period, you may be required to complete a Long Term Care Insurance Application in addition to the benefit election form.

Eligible Family Members

You can apply for coverage with Evidence of Insurability at any time after the date you become eligible for coverage by completing the benefit election form and the Long Term Care Insurance Application. These forms can be obtained from the Policyholder or Unum.

COVERAGE EFFECTIVE DATE

Your coverage will begin at 12:01 a.m. on the latest of:
- the date you are eligible for coverage if we have received your benefit election form, and you applied for coverage on or before that date;
- the date you are eligible for coverage if we have received your benefit election form, and you applied for coverage within 31 days after your eligibility;
- the date Unum approves your Long Term Care Insurance application if Evidence of Insurability is required.

Your Coverage Effective Date will be the date shown in your **Schedule of Benefits** subject to the timely payment of premium for your coverage.

WHEN COVERAGE WILL BE DELAYED FOR EMPLOYEES

If you are absent from work due to injury, sickness, Temporary Layoff or Leave of Absence on your Coverage Effective Date, coverage will not begin until you return to work in Active Employment and we receive premium for your coverage.

TEMPORARY ABSENCE FROM WORK ONCE COVERAGE HAS BEGUN FOR EMPLOYEES

If you are on a Temporary Layoff, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your Temporary Layoff begins.

If you are on a Leave of Absence, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your Leave of Absence begins.

INCREASES IN COVERAGE

After your coverage is in force, you can apply to increase coverage, based on the benefits available as shown in the **Benefits at a Glance**, by sending us a new benefit election form and a Long Term Care Insurance Application.

No increased or additional coverage will become effective unless we approve your Long Term Care Insurance Application for such change. If we approve your changes in coverage, you must pay the new premium due. You will be notified of the new premium due amount and the date it is due.

You may apply for increases in coverage at any time. Premiums currently charged may be adjusted due to changes or increases in coverage. Upon approval, the change(s) you requested will replace existing benefit option(s) or your benefit duration.

DECREASES IN COVERAGE

You have the right to reduce your coverage and lower your premium, based on the benefits available as shown in the **Benefits at a Glance**, in at least one of the following ways:
(a) reducing your maximum benefit amount; or
(b) reducing your monthly benefit amount.

You can decrease your coverage at any time by sending us a new benefit election form. Premium currently charged may be adjusted due to changes or decreases in coverage. Your **Schedule of Benefits** will reflect your new premium amount and the date it is due. The premium for reduced coverage will be based on your age used to determine your coverage currently in force.

TERMINATION OF BENEFITS

Your benefit payments under the policy will end on the earliest of:
- the day after you are no longer Chronically Ill;
- the day after the expiration of your Licensed Health Care Practitioner's Certification;
- the day after you are no longer receiving Qualified Long Term Care Services;
- the day after your Lifetime Maximum Benefit has been reached;
- the day after you die.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of:
- the day after your Lifetime Maximum Benefit has been reached;
- the day after the end of your Grace Period, if premiums for your coverage are not paid within the Grace Period;

- the day after we receive your written notification that you wish to cancel your coverage; or
- the day after you die.

Your coverage will also terminate on the earliest of the following events:
- the date the group policy terminates; or
- the date you are no longer in an Eligible Group with the Policyholder; or
- the day after the pay period ends for which premiums were last paid to us by the Policyholder for your coverage;

unless you elect to continue your coverage under the Continuation of Coverage provision.

CONTINUATION OF COVERAGE

You are eligible to continue coverage, subject to the submission of your completed Continuation of Coverage and Third Party Designation forms, if any portion of your premium:
- is paid for by the Policyholder; or
- is payroll deducted by the Policyholder.

If you meet the eligibility criteria listed below, you may elect to continue coverage on a direct bill basis. You must contact the Policyholder or Unum to obtain the Continuation of Coverage form and the Third Party Designation form. You must fully complete both forms and return them to Unum, at the address listed on the form within 60 days of:
- the date the group policy terminates; or
- the date you are no longer in an Eligible Group with the Policyholder; or
- the day after the pay period ends for which premiums were last paid to us by the Policyholder for your coverage.

If your coverage terminates because you are no longer eligible for coverage, your continued coverage will remain in force under the existing group policy. If the existing group policy terminates, your coverage may be continued subject to the terms of this certificate. 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 your continued coverage.

If you did not apply for coverage during the time you were otherwise eligible to apply for coverage, or if you were not approved for coverage during the time you were otherwise eligible for coverage, you are not eligible to apply for Continuation of Coverage.

You may not elect to continue coverage if you are not insured under the group policy on the date the group policy terminates.

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 for all insureds in the same class.

You may make changes to your continued coverage at any time. Changes must be based on the current Benefit Options available under the group policy from which you terminated. To change your coverage, you must contact Unum's home office for assistance. You will need to complete the necessary forms which may include a Long Term Care Insurance Application.

STATEMENTS

We consider any statements you make for insurance in any signed application for coverage to be complete and true to the best of your knowledge and belief. In the absence of fraud, 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 were made, we can:
- reduce or deny any claim; or

- terminate your coverage from the original effective date.

No such statements made by you will be used to deny a claim unless a copy of your statements has been given to you.

INCONTESTABILITY

If your coverage has been in force for less than six (6) months, we may rescind your coverage or deny an otherwise valid claim (relating to a Chronic Illness commencing prior to the expiration of such six (6) month period) upon a showing of misrepresentation that is material to the acceptance of coverage.

If your coverage has been in force for at least six (6) months but less than two (2) years, we may rescind your coverage or deny an otherwise valid claim (relating to a Chronic Illness commencing during such six (6) months to two (2) year period) upon a showing of misrepresentation that is ***both*** material to the acceptance of coverage ***and*** which pertains to the conditions for which benefits are sought.

If your coverage has been in force for two (2) years or more, it is not contestable upon the grounds of misrepresentation alone. Such coverage may only be contested upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

If your coverage is reinstated, the time periods applicable to this provision will be measured from the reinstatement date.

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

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

AGENT

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 our agent.

BENEFIT PROVISIONS

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

You will be eligible for a benefit if, on or after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill. Chronically Ill means you:
- are unable to perform without Substantial Assistance from another individual two (2) or more Activities of Daily Living for a period of at least 90 days; or
- have a level of Chronic Illness similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of Chronic Illness described in the first bullet; or
- require Substantial Supervision by another individual to protect you or others from threats to health and safety due to Severe Cognitive Impairment.

CONDITIONS FOR PAYMENT OF BENEFITS

To receive benefits under the policy, the following conditions must be met:
- you must satisfy the Elimination Period, if applicable;
- you must be receiving Qualified Long Term Care Services;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You must also provide us a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

You will be required to submit a Licensed Health Care Practitioner's Certification every 12 months.

A benefit will become payable once all these requirements are met.

LIMITATIONS ON PAYMENT OF BENEFITS

We will not pay benefits in excess of the coverage you chose as shown in your **Schedule of Benefits**. Benefits paid will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached. We will not pay benefits for Qualified Long Term Care Services you receive during the Elimination Period, except as described in the Respite Care Benefit and the Additional Care Benefit provisions. The policy only pays benefits if you are receiving Qualified Long Term Care Services.

BENEFIT PAYMENT

If you are eligible for a LTC Facility Monthly Benefit:

You must give us proof that you are receiving Qualified Long Term Care Services in a LTC Facility before a LTC Facility Monthly Benefit will be paid. If you are eligible for benefits for a period of less than one (1) month, we will pay you 1/30th of the LTC Facility Monthly Benefit for each day that you are Chronically Ill and receiving Qualified Long Term Care Services in a LTC Facility.

The amount of your LTC Facility Monthly Benefit is shown in your **Schedule of Benefits**.

If you selected, and you are eligible for, a Professional Home and Community Care Monthly Benefit:

We will pay 1/30th of the Professional Home and Community Care Monthly Benefit shown in your **Schedule of Benefits** for each day you are receiving Professional Home and Community Care

Services. Professional Home and Community Care Services you receive may be provided anywhere other than a LTC Facility, acute care facility or other location excluded by the policy.

You must give us written proof indicating days of Professional Home and Community Care Services provided to you before a benefit will be paid. We will also require a copy of the Licensed Home Health Care Agency's state license, if applicable, or the Licensed Home Health Care Professional's state license, if applicable, to practice in his/her respective field prior to payment of benefits.

If you selected, and you are eligible for, a Total Choice Home Care Monthly Benefit:

We will pay 1/30th of the Total Choice Home Care Monthly Benefit shown in your **Schedule of Benefits** for each day you are receiving Total Choice Home Care Services. Total Choice Home Care Services you receive may be provided anywhere other than a LTC Facility, acute care facility or other location excluded by the policy.

BED RESERVATION BENEFIT

If you are receiving a LTC Facility Monthly Benefit and your stay in the LTC Facility is interrupted due to a stay in an acute care facility, or due to a temporary absence, and a charge is made to reserve your LTC Facility accommodations, you will be eligible for a Bed Reservation Benefit. We will pay you 1/30th of the LTC Facility Monthly Benefit for each day you are absent from the LTC Facility:
- up to 90 days per calendar year if your absence is due to a stay in an acute care facility; or
- up to 30 days per calendar year for a temporary absence not related to a stay in an acute care facility.

In no event will the total number of Bed Reservation days exceed 90 days per calendar year. Bed Reservation payments will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached.

If your stay in a LTC Facility is interrupted while you are satisfying your Elimination Period, such days will be used to help satisfy your Elimination Period.

RESPITE CARE BENEFIT

If you are Chronically Ill and receiving Respite Care, but you are not receiving a LTC Facility Monthly Benefit or a Home Care Monthly Benefit, if your coverage includes home care, you will be eligible to receive Respite Care. The Respite Care Benefit you will receive is equal to 1/30th of your LTC Facility Monthly Benefit for each day you have Respite Care for up to 21 days each calendar year. You do not need to complete your Elimination Period for Respite Care payments to begin, and the days you are receiving Respite Care will count toward satisfying your Elimination Period.

Respite Care can be provided in your home, an LTC Facility, an Adult Day Health Care Facility or a similar facility approved by us. Such payments will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached.

INTERNATIONAL BENEFITS

If you have selected a Home Care Monthly Benefit, we will pay International Benefits on an indemnity basis, if you qualify under the conditions defined in this provision.

ELIGIBILITY FOR INTERNATIONAL BENEFITS

You will be eligible for International Benefits if, after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill.

CONDITIONS FOR PAYMENT OF INTERNATIONAL BENEFITS

To receive International Benefits under this Certificate, the following conditions must be met:

- you must satisfy the Elimination Period;
- you must be receiving Qualified Long Term Care Services while traveling or residing outside of the United States, its territories or possessions or Canada;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You must also provide us a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

You must obtain and provide us with any required supporting documentation. All required documentation must be provided to us in English. We reserve the right to require that you provide us with updated documentation and information at reasonable intervals. However, we will not require updates more frequently than monthly.

We reserve the right to obtain an interpreter, if necessary, and to determine who the interpreter will be.

If you are receiving International Benefits under this Certificate, you cannot be receiving any other benefits under this Certificate for the same time period. Coverage for the Additional Care, Respite Care or Bed Reservation provisions are not available outside the United States, its territories or possessions or Canada.

LIMITATIONS ON PAYMENT OF INTERNATIONAL BENEFITS

We will not pay benefits in excess of the amounts shown in your **Schedule of Benefits**. Benefits paid will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum Benefit has been reached.

INDEMNITY BENEFIT FOR PAYMENT OF INTERNATIONAL BENEFITS

The Indemnity Amount we will pay for International Benefits is equal to 75% of the Home Care Monthly Benefit shown in your **Schedule of Benefits**. Any International Monthly Benefit will be paid in United States currency. You may not assign the Indemnity Benefit.

TOTAL LIFETIME INTERNATIONAL BENEFITS AVAILABLE

The Total Lifetime International Benefit payment will be the lesser of:
- your Lifetime Maximum Benefit; or
- 72 months.

WORDS THAT HAVE A SPECIAL MEANING FOR THIS PROVISION

"Indemnity Amount" means the total monthly benefit available to you regardless of the actual charges you incur. This benefit will be paid to you if you are eligible under this Certificate for International Benefits. You must be receiving Qualified Long Term Care Services in order to receive the Indemnity Benefit.

"International" means any location outside the United States, its territories or possessions or Canada.

"International Benefit" means 75% of the Home Care Monthly Benefit shown in your **Schedule of Benefits**. This benefit will be paid to you regardless of who provides the care or where the care is provided, except for locations excluded by this Certificate.

DISCRETIONARY AUTHORITY

When making any benefits determination under the policy, we have the discretionary authority to determine your eligibility for benefits and to interpret the terms and provisions of the policy.

EXTENSION OF BENEFITS

Termination of coverage will be without prejudice to any benefits payable under the policy and any attachments (if applicable), if eligibility for such benefits or Chronic Illness began while your coverage was in force. Benefits will continue without interruption. Such extension of benefits will be limited to the duration of the payment of your Lifetime Maximum Benefit.

LEGAL ACTION

No one may start legal action to recover on the policy until 60 days after written Proof of Claim has been given to us. Legal action must be started within three (3) years after the written Proof of Claim is furnished.

LIMITATIONS AND EXCLUSIONS

PLAN EXCLUSIONS

We will not provide benefits for:
- a Chronic Illness caused by war or any act of war, whether declared or undeclared, that occurs while your coverage is in force.
- a Chronic Illness caused by intentionally self-inflicted injuries or attempted suicide, while sane.
- a Chronic Illness caused by the commission of a crime for which you have been convicted under law, or caused by your attempt to commit a crime under law.
- a Chronic Illness caused by alcoholism or drug addiction.
- any period of time while you are Chronically Ill and you are confined in a hospital, other than if you are confined to a LTC Facility that is a distinctly separate part of a hospital. This exclusion does not apply to those periods covered under the Bed Reservation Benefit.

WORDS THAT HAVE A SPECIAL MEANING

"Active Employment" means you are working for the Policyholder:
- on a full-time basis for earnings that are paid regularly; and
- are performing the material and substantial duties of your regular occupation; and
- are working at least the minimum number of hours as described under Eligible Group(s) in **Benefits at a Glance** for each plan.

Your work site must be:
- the Policyholder's usual place of business;
- an alternative work site at the direction of the Policyholder, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

"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: moving into or out of a bed, chair, or wheelchair.
- Continence: the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate or cup) or by a feeding tube.

You will be considered able to perform the above Activities of Daily Living if the ADLs can be performed by you using equipment or adaptive devices, and you do not require the Substantial Assistance of another person to perform the ADLs.

"Adult Day Health Care" means care provided in an Adult Day Health Care Facility.

We will not recognize a Family Member as an Adult Day Health Care provider for claims that you make to us under the policy, unless the Family Member is a regular employee of the Adult Day Health Care Facility or Total Choice Home Care is shown in your **Schedule of Benefits**.

"Adult Day Health Care Facility" means a facility that provides a community-based group program offering health, social and related support services to impaired adults; that operates under state licensing laws and any other laws that apply; and that meets the following tests:
- operates a minimum of five (5) days a week;
- remains open during the day;
- maintains a written record of care on each patient;
- includes a Plan of Care and record of services provided;
- has a staff that includes a full-time director and at least one (1) registered nurse who is there during operating hours for at least four (4) hours a day;
- has established procedures for obtaining appropriate aid in the event of a medical emergency;
- provides a range of physical and social support services to adults; and
- does not include overnight stays.

"Certificate" means this Certificate and any riders attached to this Certificate.

"Chronic Illness" and "Chronically Ill" mean:
- you are unable to perform, without Substantial Assistance from another individual, two (2) or more Activities of Daily Living; or
- have a level of Chronic Illness similar (as determined under regulations prescribed by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services) to the level of Chronic Illness described in the first bullet; or
- you require Substantial Supervision by another individual to protect you from threats to your health and safety due to Severe Cognitive Impairment.

We will not cover any ADL loss or Severe Cognitive Impairment that existed prior to the Effective Date of Coverage.

"Coverage Effective Date" means the date your coverage begins. Your Coverage Effective Date is shown on your **Schedule of Benefits**.

"Eligible Family Member" means a person ages 18 through 80 who is in a class of persons eligible for coverage as determined by the Policyholder and us and is residing in the United States, its territories or possessions and who is:
- the legally married spouse of an Employee.
- the natural, adoptive or step parents of an Employee or spouse.
- the natural, adoptive or step grandparents of an Employee or spouse.
- the natural, adoptive or step siblings of an Employee or spouse.
- the spouse of the Employee's natural, adoptive or step siblings.
- the spouse of the Employee's spouse's natural, adoptive or step siblings.
- the natural, adoptive or step adult children of an Employee.
- the spouse of a natural, adoptive or step adult child of an Employee.
- the domestic partner of an Employee. A domestic partner is the person named in the Employee's declaration of domestic partnership. The declaration must be executed and provided to the plan administer which gives proof that the domestic partner has had the same permanent residence as the Employee for a minimum of 12 consecutive months prior to the date insurance would become effective for that domestic partner. The Employee must not have signed a declaration of domestic partnership with anyone else within the last 12 months of signing the latest declaration. Also the domestic partner must be least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named domestic partner, and not married to anyone else. The declaration of domestic partnership must be approved and recorded by the plan administrator.

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

"Elimination Period"
If LTC Facility only is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services must be provided in a LTC Facility.

If LTC Facility with Professional Home and Community Care is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services must be provided in a LTC Facility; or by/through a Licensed Home Health Care Agency; in an Adult Day Health Care Facility; or by a Licensed Home Health Care Professional.

Each calendar week during which you receive at least one (1) day of Professional Home and Community Care Services will be counted as seven (7) days towards the completion of your Elimination Period.

If LTC Facility with Total Choice Home Care is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services

may be provided to you by anyone including a Family Member; or in a LTC Facility; or by/through a Licensed Home Health Care Agency; by a Licensed Home Health Care Professional; in an Adult Day Health Care Facility or by an informal caregiver.

Once you are Chronically Ill, your Elimination Period must be completed within a period of 730 days. You must satisfy your Elimination Period only once during the lifetime of the policy. The number of days in your Elimination Period is shown in your **Schedule of Benefits.**

"Employee" means a person who is employed by the Policyholder and who is in a class of persons eligible for coverage as determined by the Policyholder and is residing in the United States, its territories or possessions.

"Family Member" means you, your spouse, or domestic partner, or persons related to you, your spouse or domestic partner, including adopted, in-law and step relatives, such as a parent, grandparent, child, grandchild, brother, or sister.

"Grace Period" means the 31 days immediately following any Premium Due Date during which premium payment must be made.

"Home Care Monthly Benefit" means the selected Professional Home and Community Care or Total Choice Home Care Monthly Benefit as shown in your **Schedule of Benefits**.

"Homemaker Services" means assistance with activities necessary to or consistent with your ability to remain living in your residence. Homemaker Services may be provided by skilled or unskilled persons but must be provided through a Licensed Home Health Care Agency or by a Licensed Home Health Care Professional. A Family Member cannot provide Homemaker Services, unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Total Choice Home Care is shown in your **Schedule of Benefits**.

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

We will consider a person to be a Licensed Health Care Practitioner only when the person is performing tasks that are within the limits of the person's license, and such tasks are appropriate to the care of your Chronic Illness. We will not recognize a Family Member as a Licensed Health Care Practitioner for claims that you make to us under the policy.

"Licensed Health Care Practitioner's Certification" means a written certification provided by a Licensed Health Care Practitioner that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

"Licensed Home Health Care Agency" means:
- an organization that is licensed or certified by the appropriate licensing agency of the state where home care services will be provided; or certified as a home health care organization as defined under Medicare; or
- any other organization that meets all of the following tests:
  - primarily provides nursing care and other therapeutic services;
  - has standards, policies and rules established by a professional group which is associated with the organization;
  - includes at least one (1) Physician or one (1) registered nurse; and
  - includes a Plan of Care and a written record of care or services provided to be maintained for each person served by the organization; or
- a similar organization approved by us.

We will not recognize a Family Member as a Licensed Home Health Care Agency provider for claims that you make to us under the policy, unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Adult Day Health Care Facility or Total Choice Home Care is shown in your **Schedule of Benefits**.

"Licensed Home Health Care Professional" means a licensed therapist, a registered nurse, a licensed practical nurse, a licensed vocational nurse or a certified hospice caregiver operating within the scope of his or her license and/or certification. A Licensed Home Health Care Professional must provide services pursuant to a written Plan of Care and maintain patient records.

We will not recognize a Family Member as a Licensed Home Care Professional for claims that you make to us under the policy, unless Total Choice Home Care is shown in your **Schedule of Benefits**.

"Lifetime Maximum Benefit" means the total dollar amount of benefits that will be paid under the policy, as shown in your **Schedule of Benefits**, excluding any Additional Care Benefit. Your Lifetime Maximum Benefit will be adjusted to include any Benefit Increase or Inflation Protection increases, if applicable.

"Long Term Care Facility" (LTC Facility) means a facility (such as a nursing facility, an assisted living facility, a licensed boarding home, a hospice facility, a rehabilitation facility, an Alzheimer's facility or a residential care facility) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support your needs resulting from a Chronic Illness.

A LTC Facility must also:
- provide care 24 hours a day;
- provide three (3) meals a day, including special dietary requirements;
- have an employee on duty at all times who is awake, trained and ready to provide care;
- have formal arrangements for services of a Physician or nurse in the event of a medical emergency;
- be authorized to administer medication to patients on the order of a Physician; and
- have accommodations for at least three (3) inpatients in one (1) location; or
- be a facility that provides a formal program of care for terminally ill patients whose life expectancy is less than six (6) months, provided on an inpatient basis and directed by a Physician, such as a hospice facility; or
- be Medicare certified; or
- be a similar facility approved by us.

NOTE: If a facility has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a LTC Facility only if it:
- meets all of the above criteria;
- is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and
- is primarily engaged in providing not only room and board, but also care and services, which meet all of the above criteria.

A LTC Facility is NOT:
- a hospital or clinic;
- an adult family home;
- a sub-acute hospital or unit;
- a place which operates primarily for the treatment of alcoholism or drug addiction;
- the insured person's primary place of residence in an area used principally for independent residential living (including, but not limited to, unlicensed boarding homes and adult foster care facilities); or
- a substantially similar establishment.

"LTC Facility Monthly Benefit" means the LTC Facility Monthly Benefit amount shown in your **Schedule of Benefits**.

"Personal Care" means the provision of hands-on services to assist an individual with activities of daily living.

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the state in which he or she performs such function or action.

We 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, and such tasks are appropriate to the care of your Chronic Illness. We will not recognize a Family Member as a Physician for claims that you make to us under the policy.

"Plan of Care" means a written plan prescribed by a Licensed Heath Care Practitioner, based upon an assessment that evaluates your level of functional capacity. The Plan of Care must describe the necessary services to be performed, the frequency, the type of care, and the most appropriate providers for such care. The care described must be in accordance with acceptable medical and nursing standards of practice and must be appropriate for your Chronic Illness.

"Policyholder" means the entity to which the policy is issued.

"Policy Effective Date" means the date the policy begins. The Policy Effective Date is shown on the face page of the policy.

"Professional Home and Community Care Monthly Benefit" means the Professional Home and Community Care Monthly Benefit amount shown in your **Schedule of Benefits**.

"Professional Home and Community Care Services" means Qualified Long Term Care Services provided to you for at least one (1) hour or more per day by/through a Licensed Home Health Care Agency, by a Licensed Home Health Care Professional, or in an Adult Day Health Care Facility.

Professional Home and Community Care Services include:
- nursing care;
- physical, respiratory, occupational or speech therapy;
- Homemaker Services;
- hospice care; or
- other services pursuant to your Plan of Care.

Professional Home and Community Care Services does not include:
- care or services provided by a Family Member directly or through a Licensed Home Health Care Agency, an Adult Day Health Care Facility or by a Licensed Home Health Care Professional unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Adult Day Health Care Facility; or
- care or services provided by a Family Member who is a Licensed Home Health Care Professional; or
- care in LTC Facility or in an acute care hospital or other location excluded by the policy.

"Qualified Long Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by you. The services must be for your Chronic Illness and provided pursuant to a written Plan of Care; and you must obtain a Licensed Health Care Practitioner's Certification. You must be receiving Qualified Long Term Care Services in a Long Term Care (LTC) Facility or, if selected, receiving a Home Care Monthly Benefit.

"Respite Care" means short-term or periodic Qualified Long Term Care Services which are required to maintain your health or safety and to give temporary relief to your primary informal caregiver from his or her caregiving duties.

"Severe Cognitive Impairment" means a deterioration or loss in your short or long term memory; your orientation as to person, place, or time; or your deductive or abstract reasoning as reliably measured

by clinical evidence and standardized tests. Such loss can result from a sickness, injury, advanced age, Alzheimer's disease, or similar form of dementia.

"Substantial Assistance" means stand-by or hands-on assistance without which you would not be able to safely and completely perform the ADL. Stand-by assistance means the presence of another person within arm's reach of you while you are performing the ADL. Hands-on assistance means physical assistance (minimal, moderate, or maximal) without which you would not be able to perform the ADL.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another individual for the purpose of protecting you from threats to your health or safety.

"Temporary Layoff or Leave of Absence" means you are temporarily absent from Active Employment for a period of time that has been agreed to in advance in writing by the Policyholder.

Your normal vacation time or any period of Chronic Illness is not considered a Temporary Layoff or Leave of Absence.

"Total Choice Home Care Monthly Benefit" means the Total Choice Home Care Monthly Benefit amount shown in your **Schedule of Benefits**.

"Total Choice Home Care Services" means Qualified Long Term Care Services provided to you by anyone including a Family Member, by/through a Licensed Home Health Care Agency, by a Licensed Home Health Care Professional, in an Adult Day Health Care Facility or by an informal caregiver.

Total Choice Home Care Services include:
- nursing care;
- physical, respiratory, occupation or speech therapy;
- Homemaker Services;
- hospice care; or
- other services pursuant to your Plan of Care.

Total Choice Home Care Services does not include:
- care in a LTC Facility;
- care in an acute care hospital; or
- care in other locations excluded by this policy.

The terms "you" and "your" refer to the insured named in your **Schedule of Benefits**. The insured cannot be changed.

"Unum", "we", "us", and "our" mean Unum Life Insurance Company of America.

OTHER SERVICES

ADDITIONAL CARE BENEFIT

Once you are eligible for a benefit payment you will have access to Additional Care designed to assist you in living at home or in other residential housing. You do not need to complete your Elimination Period for an Additional Care Benefit payment to begin. The Additional Care must be:
- appropriate for your Chronic Illness and conform with generally accepted medical standards;
- provided pursuant to a written Plan of Care;
- recommended by a Licensed Health Care Practitioner; and
- approved by us prior to receipt of Additional Care.

The Additional Care cannot be covered by other insurance or Medicare.

We will require verification of Additional Care received. We will pay the actual expenses you incur for Additional Care, up to the Additional Care Benefit Lifetime Maximum. The Additional Care Benefit Lifetime Maximum is shown in the **Schedule of Benefits**.

The Additional Care Benefit:
- will be subject to written mutual agreement between you and us;
- may only be used for Additional Care as described under the policy;
- will not prejudice any payable claim for a covered Chronic Illness under the policy;
- will be restored under the Restoration of Benefits provision, if purchased;
- will reduce your Additional Care Benefit Lifetime Maximum;
- will not increase under any Benefit Increase or Inflation Protection benefit, if purchased; and
- will no longer be available once your Additional Care Benefit Lifetime Maximum has been reached.

If for any reason you do not wish to receive Additional Care, your benefits will continue according to the provisions of the policy.

WORDS THAT HAVE A SPECIAL MEANING IN THIS SECTION

"Additional Care" means special services, equipment or Caregiver Training designed to assist you in living at home or in other residential housing. Additional Care may include:
- assistance in locating long term care providers and caregivers in your area (this service is also available even if you are not eligible for benefits);
- a visit from a Licensed Health Care Practitioner who will develop your Plan of Care;
- a visit from a home safety expert who will assess your residence and offer suggestions for increased personal safety;
- purchase or rental of a medical alert service;
- purchase or rental of durable medical equipment;
- home modifications for your support; or
- Caregiver Training.

"Additional Care Benefit Lifetime Maximum" means the total dollar amount of benefits that will be paid as Additional Care Benefit under the policy, as shown in your **Schedule of Benefits.**

"Caregiver Training" means the training of an informal caregiver to care for you in your home or in other residential housing. An informal caregiver may be a Family Member, relative or friend. We will not pay for training someone who is a Licensed Home Health Care Professional. Training can occur while you are confined in a hospital or a LTC Facility, if the training will make it possible for you to return to your home or to other residential housing where you will be cared for by the informal caregiver who received the training.

CLAIM INFORMATION

NOTICE OF CLAIM

You must notify us of your claim at our home office within 30 days of the date of Chronic Illness. The notice should include your name and the policy number. If it is not possible for you to give us notice within this time period, it must be given as soon as reasonably possible.

CLAIM FORM

We will send you our initial claim form and Authorization to Disclose Information when we receive your notice of claim. If you do not receive our forms within 15 days after notice of claim is given, you can send us written proof of claim without waiting for the forms.

HOW TO FILE A CLAIM

You or your authorized representative must fully complete the claim form, attaching additional pages if more space is needed, to fully describe your condition and care needs. The claim form and Authorization to Disclose Information must be signed by you, or by your authorized representative (such as a person to whom you have granted Power of Attorney).

PROOF OF CLAIM

You must give us initial proof of claim, at your expense, no later than 90 days after the date your Chronic Illness begins. If it is not possible for you to give proof within this time limit, we will not reduce or deny your claim if proof is given as soon as reasonably possible. However, proof of claim must be given no later than one (1) year after the time proof is otherwise required, unless you are legally incapacitated.

The proof of your claim must include:
- the date your Chronic Illness began;
- the cause of your Chronic Illness;
- the extent of your Chronic Illness; including restrictions and limitations preventing you from performing the ADLs;
- a Licensed Health Care Practitioner's Certification;
- a copy of your Plan of Care;
- a Physician's statement and/or copies of relevant medical records from any Physician or health care provider involved in your care;
- the name and address of any hospital or institution where you received treatment, and/or the name and address of any health care provider who treated you, including all attending Physicians: and
- verification of care or services provided.

In addition to the claim form and the Authorization to Disclose Information, we may require, at our expense, that you or your caregiver provide or participate in one (1) or more of the following as proof of claim:
- an Assessment;
- a personal interview with you or review of your records by our representative at such time and with such frequency as we reasonably require;
- an independent medical examination or functional capacity evaluation in determining proof of continuing Chronic Illness. This may include related tests, as are reasonably necessary to the performance of the examination or evaluation by a Physician or specialist, appropriate for the condition at such time and place and with such frequency as we reasonably require. We reserve the right to select the examiner. We will pay for the examination, including the costs associated with your travel to the examination, if the examination cannot be conducted locally; and /or
- such other proof as is reasonable and necessary.

"Assessment" means a personal interview of you, done by us or our representative, to assist in the determination of your Chronic Illness at the time of your claim.

We reserve the right to request additional information necessary to our claim determination from you, your Physician, or other health care providers. You must promptly sign and return any forms we require in order to process your claim.

We will request proof of continued Chronic Illness or an updated written Plan of Care at intervals determined by us.

You will also be required to submit a Licensed Health Care Practitioner's Certification every 12 months, as required under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

You or your representative(s) must respond within 30 days of the request for an updated Plan of Care, proof of continued Chronic Illness or additional information for us to continue to evaluate and process your claim. We reserve the right to deny your claim or stop sending you payments if the appropriate information is not submitted.

You or your representative(s) must notify us immediately when you are no longer Chronically Ill or you are no longer receiving Qualified Long Term Care Services.

WHEN CLAIMS ARE PAID

Benefits payable under the policy will be paid before the end of the month for each day for which you were entitled to benefits during the prior month. Benefit payments will end as provided in the **TERMINATION OF BENEFITS** provision.

TO WHOM CLAIMS ARE PAID

All benefits are payable directly to you unless at the time of claim you or your authorized representative have requested in writing that payment be made otherwise.

If you are eligible to receive a benefit and you die prior to receiving the benefit payment, any remaining benefits that are owed to you will be payable to your probate estate, if one has been established. In the event that there is no probate estate, the remaining benefits will be paid, at our option, to your Family Member or to another recipient deemed by us to be entitled to such benefits. If we pay benefits in good faith under this provision, we will have satisfied our obligations under the policy and will not have to pay such benefits again.

CLAIM OVERPAYMENT

If for any reason benefits have been paid for a period for which you were not entitled to benefits, repayment of the overpayment must be made to us within 45 days of the notice to you or your representative. We may recover any amounts not repaid by offsetting them against any amounts otherwise payable to you under the policy or by other reasonable means.

RIGHT OF APPEAL

You have the right to appeal any claim decision. Your appeal must be in writing and must be sent to us within 90 days of your denial notice.

We will notify you in writing if a claim or any part of a claim is denied. The denial letter will state:
- the specific reason(s) for the denial with reference to the applicable policy provision(s);
- a description of any additional material or information that is necessary to complete the claim;
- an explanation of why the additional material or information is necessary;
- a statement describing your access to documents; and
- a statement describing your appeal and legal rights to bring suit.

If you are not satisfied with the reason for the denial, you or your authorized representative may ask to have the claim reviewed by us. Your appeal must be in writing and should include all supporting

materials or information that will help us to review the claim. We will review your appeal and all new information submitted, and notify you or your representative of our decision within 30 days of receiving the appeal. 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 we expect to make a decision. A decision shall be made no later than 120 days following receipt of the initial request for review. We can extend the time periods if we have not received needed information from you. In some cases, we may request that you provide additional information to assist in the review.

You or your authorized representative may request copies of those documents that are relevant to your claim. We will make available, within 30 days of a written request from you or your authorized representative, all information directly related to the denial of your claim.

GENERAL INFORMATION

PREMIUM DUE DATES AND PAYMENTS

All premiums due for your coverage, including any adjustments, must be paid on or before the applicable Premium Due Date. Premium must be sent to us at 2211 Congress Street, Portland, Maine 04122 or at the address designated on the bill for that purpose. Premiums are payable in U.S. currency only.

GRACE PERIOD

The Grace Period for coverage that is paid through a payroll deduction plan is the 31 consecutive days that begin with the Premium Due Date. Your coverage will remain in effect during that time. Termination will not prejudice any payable claim for a covered loss that begins prior to the termination of coverage. The Grace Period for coverage that is billed directly to you and/or your designated representative is the 31 consecutive days that begin with the day a premium is due. Your coverage will remain in effect during the Grace Period. Termination will not prejudice any payable claim for a covered loss that begins prior to the termination of coverage.

There is no Grace Period for the first premium due.

If Unum, at its sole discretion, agrees to waive your Grace Period in any instance, such agreement will not preclude or prejudice enforcement of your Grace Period in any other instance.

UNINTENTIONAL LAPSE FOR DIRECT BILLED COVERAGE

When you applied for this coverage, you were given the opportunity to designate at least one (1) person, in addition to yourself, who is to receive notice of lapse or termination of your coverage for nonpayment of premium. Designation does not constitute acceptance of any liability by the third party for services provided to you. You will be notified of your right to change this written designation no less often than once every two (2) years.

Your coverage will not lapse or be terminated for nonpayment of premium unless we notify you, and those persons designated by you (if any) to receive notice of lapse or termination, at least 30 days before the effective date of lapse or termination. Notice will be given by first class United States mail, postage prepaid. Notice will not be given until 30 days after a premium is due and unpaid and will be deemed to have been given as of five (5) days after the date of mailing. However, termination of your coverage will not prejudice any payable claim for a covered loss which begins prior to policy termination.

If premium payment for your coverage changes from payroll deducted to direct billed, you will have 60 days after you are no longer on the payroll deduction plan to designate at least one (1) person, in addition to yourself, to receive notice of lapse or termination of your coverage for nonpayment of premium.

REINSTATEMENT

If your coverage terminates because a premium is not paid by the end of the Grace Period, you may request to reinstate your coverage at any time within six (6) months after the policy's termination date.

In order to reinstate coverage, the following requirements must be met:
- you must complete a Long Term Care Insurance Application;
- we must approve your Long Term Care Insurance Application; and
- you must pay all unpaid premium.

If we approve your reinstatement application, we will reinstate your coverage as of the date it was terminated and all of its terms and conditions will apply. If we issue a prepayment agreement and do not approve or disapprove your Long Term Care Insurance Application within 45 days from the date

of the prepayment agreement, we will reinstate your coverage on that 45th day. The effective date of the reinstatement will be the date your coverage terminated.

The reinstated coverage WILL NOT cover any Chronic Illness, which is excluded by name or description in the policy.

REINSTATEMENT OF TERMINATED COVERAGE DUE TO CHRONIC ILLNESS

If you become Chronically Ill and your coverage terminates because a premium is not paid by the end of the Grace Period, you may request to reinstate your coverage at any time within six (6) months after the policy's termination date.

In order to reinstate your coverage, the following requirements must be met:
- you must provide proof that your Chronic Illness began prior to the date your coverage terminated; and
- you must pay all unpaid premium.

If you meet these requirements, we will reinstate your coverage on the date your coverage terminated and all the terms and conditions of the policy will apply.

The reinstated coverage WILL NOT cover any Chronic Illness, which is excluded by name or description in the policy.

If the coverage is reinstated, the time periods applicable to this provision will be measured from the reinstatement date.

REINSTATEMENT AFTER MILITARY SERVICE

You have the right to place your coverage in suspension while you are on a Leave of Absence from the Policyholder for active military service. "Suspension" is a process of placing your coverage on inactive status. No premium payments are required while coverage is suspended, but there is no coverage during that period of time. A request to suspend coverage due to entering full-time, active military service must be made in writing and include the policy number.

If the duration of your active military service is five (5) years or less and you return to Active Employment with the Policyholder within 90 days of the end of that service, your coverage will be reactivated without evidence of insurability so long as the policy remains in force. You must complete a written election to reinstate and pay the required premium.

If you do not terminate your full-time active duty within five (5) years from the date your coverage was suspended, or you do not reactivate your coverage within 90 days following your return to Active Employment with the Policyholder, your coverage will be deemed terminated as of the date suspension began. If your coverage has terminated, you may re-apply for coverage with evidence of insurability by filling out the benefit election form and the Long Term Care Insurance Application so long as the policy remains in force.

WAIVER OF PREMIUM

After you have satisfied your Elimination Period, and while you are receiving benefits under the policy and any attachments, we will waive premium payments. However, premium payments will not be waived if you are only receiving Respite Care Benefits or Additional Care Benefits.

If benefits are no longer payable, you must resume premium payments. We will notify you of the amount of your next premium payment and the date it is due.

REFUND OF PREMIUM AFTER DEATH

If you die while insured under the policy, we will refund any pro rata portion of your premium paid covering the period after your death. We will make the refund within 30 days after we receive written notice of your death. Payment will be made to your estate.

REFUND OF PREMIUM DUE TO CANCELLATION OF COVERAGE

In the event your coverage under the policy is cancelled by you, we will, within 30 days of the effective date of such cancellation, refund the premium paid for any period beyond the end of the month following the date of cancellation of coverage.

CONTINGENT NON-FORFEITURE

If your premium rates increase to a level which results in a cumulative percentage increase in your annual premium over your initial annual premium, that is greater than or equal to the percentage shown in the chart below based on your original issue age, you may choose to do one (1) of the following:

(a) continue to pay the required premium;
(b) reduce your benefits provided by the current coverage without the requirement of underwriting so that your required premium payments are not increased;
(c) elect to convert your coverage within 120 days of the premium increase effective date to a paid up status with Contingent Non-Forfeiture; or
(d) terminate your group coverage within 120 days of the premium increase effective date and be automatically converted to Contingent Non-Forfeiture.

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

If you stop making premium payments under (c) or (d) above, this means that the Certificate will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Benefit. Your Lifetime Maximum Benefit under this provision will be equal to the total premium paid up to the date you stopped paying premiums.

In no event will your Lifetime Maximum Benefit:
- be less than 30 days of your LTC Facility Monthly Benefit; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains a Benefit Increase option, Inflation Protection Benefit option, Return of Premium at Death option and/or Restoration of Benefits option, no Benefit Increase, Inflation Protection Benefit, Return of Premium at Death or Restoration of Benefits will be made after the end of the period for which premiums were last remitted to us for your coverage.

Triggers For A Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%

62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

MISSTATEMENT OF AGE

If your age has been misstated, any benefit payable will be changed to the amount which the premium paid would have bought for the correct age.

If we accept premium for coverage that we would not have issued or which would have ceased according to the correct age, our only liability is to refund the premium for the period not covered.

CLERICAL ERROR

Clerical error or omission by us will not:
- prevent you from receiving coverage or benefits;
- entitle you to receive coverage or benefits;
- affect the amount of your coverage; or
- cause your coverage to begin or continue when the coverage would not otherwise be effective.

CONFORMITY WITH FEDERAL STATUTES

We have designed the policy to meet the qualified long term care insurance requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended. In the future if changes are needed to maintain the tax status of the policy, we will make every reasonable effort to amend the policy to maintain its tax status. The Policyholder will be given the opportunity to amend the policy in order to preserve its favorable federal income tax treatment. Your Certificate may be affected by any such amendments. If the required changes are not made, the policy and your coverage may lose their status as a qualified long term care insurance policy.

CONFORMITY WITH STATE STATUTES

Coverage under the policy may be amended as required to reflect the minimum requirements of applicable state law.

TAX NOTE

Since benefits are paid without regard to actual charges you incur, part of the benefit could be considered taxable income if they exceed the daily benefit amount limit prescribed under Section 7702B(b) of the Internal Revenue Code of 1986, as amended (referred to as a "Per Diem" limit). This "Per Diem" limit is indexed for inflation. You should consult with your tax advisor.

ADDITIONAL BENEFITS

The Additional Benefits available under the policy are described in this section. Refer to your **Schedule of Benefits** for any Additional Benefits you may have selected.

ACCELERATED PAYMENT OPTION

If your coverage includes:

10 YEAR - ACCELERATED PAYMENT OPTION

WORDS THAT HAVE SPECIAL MEANING IN THIS PROVISION

"10 Policy Years" means payment of premiums that cover 10 consecutive years of insurance coverage beginning with the Accelerated Payment Option Coverage Effective Date shown in your **Schedule of Benefits**. Any period for which premium has been waived for a Chronic Illness will count toward the 10 policy years.

Provided that your premium payments have been paid for 10 policy years, your coverage will automatically be renewed for the rest of your life without any further premium payments. The LTC Facility Monthly Benefit and the Lifetime Maximum Benefit of your continued coverage will be the amounts in effect on the Accelerated Payment Option Coverage Effective Date shown in your **Schedule of Benefits**. If you have purchased Benefit Increase or Inflation Protection, your LTC Facility Monthly Benefit and Lifetime Maximum Benefit will continue to increase after the required premium payment period ends and are subject to all terms and conditions of the Benefit Increase or Inflation Protection provision.

The Accelerated Payment Option is subject to all the terms and conditions of the policy. If you change your Accelerated Payment Option premium payment mode, there is no premium credit available. Once all premiums have been paid, the pro rata Refund of Premium After Death provision in your Certificate is no longer applicable.

CONTINGENT NON-FORFEITURE FOR FIXED PREMIUM PAYMENT PERIOD

If your premium rates increase to a level that results in a cumulative increase in your annual premium that is equal to or exceeds the percentage of your initial annual premium, shown in the chart below based on your issue age; and your coverage lapses within 120 days of the due date of the premium increase; and the ratio described in item (c) below is forty percent (40%) or more, you may elect to:

(a) continue to pay the increased premium, with no change in benefits;
(b) reduce your benefits provided by the current coverage without the requirement of underwriting so that your required premium payments are not increased;
(c) convert your coverage to a paid-up status where the benefit amount payable is ninety percent (90%) of the amount payable in effect immediately prior to lapse, times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period; or
(d) convert your coverage to a paid-up status under the Contingent Non-Forfeiture provision of the policy, if eligible.

A default or lapse at any time during the 120-day period shall be deemed your election to convert your coverage to a paid-up status as described in item (c) above.

Triggers for a Substantial Premium Increase:

Issue Age	**Percent Increase Over Initial Premium**
Under 65	50%
65 - 80	30%
Over 80	10%

FOR EXAMPLE:

Meets the 40% Requirement Described Above	**Does Not Meet the 40% Requirement Described Above**
Your LTC Facility Monthly Benefit Amount = $3,000 (multiply your LTC Facility Monthly Benefit Amount by 90%): **$3,000 x .90 = $2,700**	Your LTC Facility Monthly Beneft Amount = $3,000 (multiply your LTC Facility Monthly Benefit Amount by 90%): **$3,000 x .90 = $2,700**
Number of months in premium paying period = 120 months	Number of months in premium paying period = 120 months
Number of completed months of paid premiums = 48	Number of completed months of paid premiums = 12
48 divided by 120 = 40%	**12 divided by 120 = 10%**
Monthly LTC Facility Beneft Amount payable under paid-up status = $2,700 x 40% = $1,080	**N/A: Coverage will convert according to item (d) above, if applicable**
If your coverage includes home care, your home care benefit amount payable will be the LTC Facility Benefit Amount payable multiplied by the home care percentage you've elected.	**N/A: Coverage will convert according to item (d) above, if applicable**

In no event will your Lifetime Maximum Benefit:
- be less than 30 days of your LTC Facility Monthly Benefit; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains a Benefit Increase option, Inflation Protection Benefit option, Return of Premium at Death option and/or Restoration of Benefits option, no Benefit Increase, Inflation Protection Benefit, Return of Premium at Death or Restoration of Benefits will be made after the end of the period for which premiums were last remitted to us for your coverage.

TERMINATION OF THE ACCELERATED PAYMENT OPTION

Your Accelerated Payment Option will terminate on the day any portion of your coverage terminates as provided in the Termination of Coverage provision.

INFLATION PROTECTION

If your coverage includes:

5% COMPOUND INFLATION PROTECTION

Your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date anniversary by 5% of your LTC Facility Monthly Benefit in effect on that date. Increases will be automatic and will occur regardless of your health and whether or not you are eligible for or are receiving benefit payments under the policy and any attached rider(s). Your premium will not increase due to automatic increases in your LTC Facility Monthly Benefit. Your remaining Lifetime Maximum Benefit Amount will also increase by 5%.

In the event you decide to terminate this Inflation Protection prior to the benefit being paid, you have the right to purchase the inflated benefit amount at your original issue age or you can revert the benefit amount to the one you chose when you enrolled for this provision.

TERMINATION OF 5% COMPOUND INFLATION PROTECTION

Your Compound Inflation Protection will terminate on the earlier of:
- the day your coverage continues under any Non-Forfeiture Benefit; or
- the day any portion of your coverage terminates as provided in the Termination of Coverage provision.

Unum Life Insurance Company of America

ENDORSEMENT TO CERTIFICATE OF INSURANCE

IMPORTANT INFORMATION FOR CONNECTICUT RESIDENTS

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 to read as follows:

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

PLAN EXCLUSIONS

We will not provide benefits for:

- a Chronic Illness caused by war or any act of war, whether declared or undeclared, that occurs while your coverage is in force,
- a Chronic Illness caused by intentionally self-inflicted injuries or attempted suicide, while sane,
- a Chronic Illness caused by the commission of a felony for which you have been convicted under state or federal law,
- a confinement due to alcoholism or drug addiction,
- any period of time while you are Chronically Ill and you are confined in a hospital, other than if you are confined to a LTC 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,
- any period of time while you are Chronically Ill and you are outside the United States, its territories or possessions or Canada for 30 consecutive days or longer if Home Care Monthly Benefits are not selected.

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

You have a Pre-existing Condition if medical advice, treatment, care or services including consultation or diagnostic measures or prescription drugs were received or recommended in the six (6) months just prior to your Coverage Effective Date; or you took prescribed drugs in the six (6) months just prior to your Coverage Effective Date.

We will not consider for any purposes an ADL loss or onset of Severe Cognitive Impairment that occurs in the six (6) months after your Coverage Effective Date if the ADL loss or Severe Cognitive Impairment is caused by, contributed to by or results from a Pre-existing Condition.

If you were required to apply for coverage by completing a Long Term Care Insurance Application and we approved your application, the Pre-existing Condition provision will not apply to you.

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

If your coverage has been in force for six (6) months or less, we may:

- rescind your coverage upon a showing of misrepresentation that is material to the acceptance of coverage; or

- deny an otherwise valid claim relating to a Chronic Illness commencing prior to the expiration of such six (6) month period upon a showing of misrepresentation that is material to the acceptance of coverage.

If your coverage has been in force for at least six (6) months, we may:

- rescind your coverage upon a showing of misrepresentation that is both material to the acceptance of coverage and which pertains to the conditions of your Chronic Illness, or
- deny an otherwise valid claim relating to a Chronic Illness commencing during such six (6) months to two (2) year period, upon a showing of misrepresentation that is both material to the acceptance of coverage and which pertains to the conditions of your Chronic Illness.

If your coverage has been in force for two (2) years or more, your coverage may be rescinded only for nonpayment of premium.

If your coverage is reinstated, the time periods applicable to this provision will be measured from the reinstatement date.

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.

4) The **"Chronic Illness"** and **"Chronically Ill"** definitions are changed to state:

"Chronic Illness" and "Chronically Ill" mean:

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

5) The **"CONTINGENT NON-FORFEITURE"** provision is change to state:

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

(a) continue to pay the required premium,
(b) reduce your benefits provided by the current coverage without the requirement of underwriting so that your required premium payments are not increased,
(c) elect to convert your coverage within 120 days of the premium increase effective date to a paid up status with Contingent Non-Forfeiture; or,
(d) terminate your group coverage within 120 days of the premium increase effective date and be automatically converted to Contingent Non-Forfeiture.

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

If you stop making premium payments under (c) or (d) above, this means that the certificate will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Benefit. Your Lifetime Maximum Benefit under this provision will be equal to the total premium paid up to the date you stopped paying premiums.

In no event will your Lifetime Maximum Benefit:
- be less than 30 days of your LTC Facility Monthly Benefit; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains a Benefit Increase option, Inflation Protection Benefit option, Return of Premium at Death option and/or Restoration of Benefits option, no Benefit Increase, Inflation Protection Benefit, Return of Premium at Death or Restoration of Benefits will be made after the end of the period for which premiums were last remitted to us for your coverage.

Triggers For A Substantial Premium Increase

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

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

Additional Summary Plan Description Information

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

Name of Plan:
Overlake Hospital Medical Center Health Care Plan

Name and Address of Employer:
Overlake Hospital Medical Center
1231 116th Ave NE
Suite 550
Bellevue, Washington
98004-3804

Plan Identification Number:
a. Employer IRS Identification #: 91-0652651
b. Plan #: 502

Type of Welfare Plan:
Long Term Care Insurance

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 Number:
Overlake Hospital Medical Center
1231 116th Ave NE
Suite 550
Bellevue, Washington
98004-3804
(425) 688-5930

Overlake Hospital Medical Center 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:
Overlake Hospital Medical Center
1231 116th Ave NE
Suite 550
Bellevue, Washington
98004-3804

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 148524 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

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

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The Policy or a plan under the Policy can be cancelled:
- by Unum; or
- by the Employer.

Unum may terminate the Policy by written notice of at least 45 days if:
- the number of Employees covered under this Policy falls below 10; or
- the Employer does not promptly report to Unum the names of any Employees who are added or deleted from the Eligible Group;
- the premium is not paid in accordance with the provisions of this Policy that specify whether the Employer, the Employee, or both, pay the premiums; or
- Unum determines that there is significant change in the size, occupation or age of the Eligible Group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Employer and/or it Employees.

Unum may terminate the Policy if required to do so by law. In this event, Unum will give the Employer at least 90 days written notice prior to the date this Policy is to be terminated. The Policy will be considered terminated as of the last day of the calendar month following the 90 day written notice of termination.

The Policy will terminate if the Employer does not pay all premiums due within the Grace Period. In this event, unless otherwise required by law, this policy will automatically terminate [(without any further notice to the Employer)] effective as of the last day of the Grace Period.

The Employer can terminate this policy at any time if it delivers written notice to Unum at least 31 days before the termination date. In this event, the Policy will be considered terminated as of the last day of the calendar month coincident with or next following the end of the 31 day notice period.

Termination of the Policy will be without prejudice to any benefits payable to a person insured under the Policy and any attached riders if eligibility for such benefits or Chronic Illness began while that person's Long Term Care insurance was in force, and continues without interruption after termination. Such extension of benefits will be limited to the duration of the payment of that person's Lifetime Maximum Benefit.

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 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:
- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- 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 a right to:
- submit a request for review, in writing, to Unum;
- 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
- 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 eligibility 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 evaluating those decisions.

Our Commitment to Privacy

We understand 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.

Unum 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.

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.

ACCESS TO 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 the NPI we have about you is incorrect, please write to 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.

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.

CONTACTING US
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, C476, 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.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company and The Paul Revere Life Insurance Company.

MK-1883 (09/15)

NOTICE OF PRIVACY PRACTICES

For long term care: expense-based cancer, hospital confinement, intensive care policies: certain medical coverage's, 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.

Unum and Colonial Life 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. We are 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 a material change to this notice, a revised notice will be provided to each policyholder then covered by a health plan.

Uses and Disclosures of PHI for Treatment, Payment or Operations

- For Treatment - We are not a health care provider (a doctor, for example) and do not engage in "treatment" of individuals as a health care provider 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 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.

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.

*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.

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/Group Health Plan. 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.

Genetic Information. We may not use or disclose PHI that is genetic information for underwriting purposes for all health plans excluding long term care.

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

We will not sell your PHI without your express written authorization to do so. With certain limited exceptions, we will not use or disclose psychotherapy notes for any purpose, and we will not use or disclose PHI for marketing purposes.

Other uses and disclosures of PHI about you not described in this notice 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 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.Unum.com. If you would like to have another paper copy of this Notice, send a written request to the 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.

Breach. You have a right to receive notification of a breach involving your unsecured PHI.

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.

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
Unum Group
2211 Congress Street, C476
Portland, ME 04122

For further information about matters covered by this notice, please contact the Privacy Officer at the above address. Unum customers may also call 1 (800) 227-4165. Colonial Life & Accident customers please call 1 (800) 325-4368.

Unum 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 & Accident Insurance Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance Company.

Effective Date of This Notice: September 23, 2013, G-73568 (9-13)

MK-3241(8-13)

PROTECTION FOR YOU AND YOUR INSURANCE POLICY
THE WASHINGTON LIFE AND DISABILITY INSURANCE GUARANTY ASSOCIATION

PREFACE

This brochure briefly describes the coverage provided through the Washington Life & Disability Insurance Guaranty Association ("Association").

The Association is a nonprofit unincorporated legal entity created by the Washington Life and Disability Insurance Guaranty Association Act, Chapter 48.32A RCW ("Act"). Every life and disability insurance company authorized to do business in Washington is a member of the Association. A Board of Directors ("Board"), composed of representatives from member insurers, and the Insurance Commissioner, ex officio, oversee the operation of the Association. The expenses of the Association are paid by assessments made against each member insurer. Persons covered by the Act are not charged for the expenses of the Association or the protection provided under the Act.

Coverage is provided for certain life and disability insurance. However, the Association does not cover all such insurance. Coverage that is provided is subject to the limitations and exclusions provided by the Act.

The purpose of this brochure is to help you understand the general nature and the conditions of the protection provided under the Act. It is only a summary, however, and if you have specific questions that are not discussed here you may contact either the Association or the Office of the Insurance Commissioner.

Washington Life and Disability Insurance
Guaranty Association Company
P.O. Box 2292
Shelton, WA 98584
360-426-6744

Supervision Division
Office of the Insurance Commissioner
P.O. Box 40259
Olympia, WA 98504-0259
360-725-7214

QUESTIONS AND ANSWERS

1. WHAT INSURANCE POLICIES ARE COVERED UNDER THE ACT?

The Act applies to life insurance policies, disability insurance policies, and annuity contracts issued by an insurance company authorized to do business in Washington. The term "disability insurance," as used in the Act, includes not only disability income insurance, but also policies commonly referred to as "health insurance" (which includes long term care policies). Together, all of these policies and contracts are sometimes referred to as "covered policies," a term used in this brochure.

2. ARE THERE POLICIES OR INSURERS NOT COVERED BY THE ACT?

The Act specifically excludes certain types of policies or portions of policies, including, but not limited to: The portion of a policy not guaranteed by the insurer; the portion of a policy to the extent the interest rate or crediting rate exceeds the limits in the Act; policies of reinsurance, unless assumption certificates have been issued; policies issued in Washington by an insurer at a time when the insurer was not licensed or did not have a certificate of authority; policies issued to a self-insured plan or program; certain unallocated employee benefit plan annuities protected by federal law; and unallocated annuity contracts not issued to or in connection with a benefit plan or a government lottery.

The Act also does not apply to policies or contracts issued by health care service contractors, health maintenance organizations, fraternal benefit societies, self funded multiple employer welfare arrangements, mandatory state pooling plans, mutual assessment companies, insurance exchanges, or an organization that has a certificate or license limited to issuance of certain charitable gift annuities.

3. WHO IS PROTECTED UNDER THE ACT?

You are covered by the Act if you are an owner of or certificate holder under a policy or contract (other than an unallocated annuity contract or structured settlement annuity), and:
- You are a Washington resident; or
- You are not a Washington resident, but only if: the insurer is domiciled in Washington; there is an association similar to the Washington Association in your state of residency; and you are not covered in your state of residency, because the insurer was not licensed in that state; or
- You are a beneficiary, assignee, or payee of one of the above, regardless of where you reside (except for nonresident certificate holders under group policies).

Owners of unallocated annuity contracts are covered if the contract was issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in Washington, or the contract was issued to or in connection with a government lottery and the owner is a Washington resident.

A payee under a structured settlement annuity (or beneficiary of a deceased payee) is also covered, if the payee is a Washington resident, or the payee is not a Washington resident, but the contract owner is a resident; or the insurer that issued the annuity is domiciled in Washington and coverage is not available in the state in which the payee resides.

Residency is generally determined at the time of entry of an order of liquidation against the insurer. If you move to another state and reside there when such an order is entered, you may still have protection under the law of that state. You should contact the insurance department in your new state of residence to find out about guaranty act protection there.

4. HOW DOES THE ASSOCIATION PROTECT COVERED PERSONS AGAINST LOSS?

After an order of liquidation is entered against a company, the Association begins its work of carrying out the purpose of the Act, which is to assure the performance of insurance obligations of that company. The Association is authorized to carry out its duties by working with insurance companies in good standing to assume or take over the covered policies. The association may also directly provide benefits and coverage as authorized by the Act. The Association has the authority to collect the funds necessary to provide protection to covered persons against losses on their covered policies.

5. WHERE DOES THE ASSOCIATION GET THE MONEY TO PROVIDE THIS PROTECTION?

The Association is authorized to collect money from all life and disability insurance companies doing business in Washington. The funds collected from an assessment are used to pay claims to covered persons and/or to fund the assumption of covered policies by another insurer.

6. DOES THE ASSOCIATION PAY OUT THE MONEY IT COLLECTS RIGHT AWAY OR DO COVERED PERSONS HAVE TO WAIT?

The Association generally cannot make an assessment for covered policies issued by a company until after an order of liquidation has been entered against the company, and a reasonable estimate can be made of the amount of money needed. Insurance companies receiving an assessment notice must make their payments within thirty days.

Because it takes time for an action to be commenced against a financially impaired insurer, for a Court to issue an order, and for funds to be collected to satisfy the obligations of that insurer, some delay, hopefully short, is unavoidable before payments can be made. Although it is impossible to predict how long this process will take in any given case, an average time period of twelve to eighteen months is not unusual.

When necessary, the Association may borrow money to make payments more promptly, particularly in cases that will take an unusual amount of time to be resolved.

7. WHAT IS THE AMOUNT OF PROTECTION PROVIDED BY THE ACT?

The Act provides the following maximum amounts of protection:

Life Insurance Death Benefits..... $500,000

Disability Benefits and Health Benefits (including Long Term Care Benefits)..... $500,000

Present Value of Individual Annuities..... $500,000

Unallocated Annuity Contracts, other certain government retirement plans (limit is per contract owner or plan sponsor)..... $5,000,000

Government Retirement Plans in Unallocated Annuities established under Internal Revenue Code § § 401, 403(b), or 457 (limit is per participant) $100,000

This protection becomes effective at the time of entry of a Court order of liquidation against the insurer. Of course, if the amount owed under the contract or policy is less than the maximum benefit under the Act, the covered person will be entitled to protection only up to the actual amount owed.

Furthermore, the maximum protection available to each covered person remains the same, regardless of the number of contracts through which he or she has a claim.

8. IF A HUSBAND AND WIFE EACH INDIVIDUALLY OWN A COVERED POLICY, IS THE PROTECTION UNDER THE ACT PROVIDED TO EACH OF THEM?

Yes. As long as the residency requirements are met, both would be entitled to the protection provided by the Act, up to the maximum amount.

9. WHY DOESN'T MY INSURANCE COMPANY ADVERTISE THE FACT THAT ITS POLICIES AND CONTRACTS ARE PROTECTED UNDER THE ACT?

Under Washington law, insurance companies are prohibited from advertising that their policies or contracts may be covered under the Act.

You should not rely on coverage under the Act when selecting an insurance company.

10. WHY HASN'T MY AGENT TOLD ME ABOUT THE GUARANTY ACT?

Your insurance agent is subject to the same prohibitions as your insurance company. As a representative of the company, an agent must exercise great care when soliciting business and consequently, will generally not discuss the subject of a guaranty act with clients.

11. WHO SHOULD I CONTACT IF I BELIEVE THERE HAS BEEN A VIOLATION OF THE ACT?

You should contact the Association if you believe your rights have been violated under the Act. If you are dissatisfied with the actions of the Association, you may also contact the Office of the Insurance Commissioner.

CONCLUSION

This notice has been prepared by the Washington Life and Disability Insurance Guaranty Association. Its purpose is to inform the public in a general way of the protections that are available in this state on insurance policies and annuity contracts issued by companies authorized to do business in

Washington. The Association does not, by this notice, endorse any company or its products, but rather seeks to address some of the concerns that you may have regarding the security of insurance policies and annuity contracts.

For more information or answers to specific questions you may contact the Washington Life and Disability Insurance Guaranty Association or the Office of the Insurance Commissioner, whose addresses and telephone numbers are shown in the Preface.

This notice is prepared by and made available through the Washington Life and Disability Insurance Guaranty Association, which has granted member insurance companies permission to reproduce and distribute the notice. It is the responsibility of the company, or any representative of a company, reproducing this notice, to ensure that the use thereof does not violate applicable laws or regulations.