



County of Travis

Your Group Long Term Care Plan

Policy No. 205655 011

Underwritten by Unum Life Insurance Company of America

3/9/2012

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

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.

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.

IMPORTANT CAUTION 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 medical and other questions you answered in your application. A copy of your Long Term Care Insurance Application was retained by you when you applied. If for any reason any of your answers are incorrect or untrue, contact us immediately at the address stated below to the attention of the Long Term Care Division. If your answers are incorrect or untrue, we may deny benefits or void your coverage. The best time to clear up any questions is now, before a claim arises.

NOTICE TO BUYER

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 policy limitations. In addition, you are advised that based on current health care cost trends, the benefits provided by your Certificate may be significantly diminished in terms of real value to you, depending on the amount of time which elapses between the date of purchase and the date upon which you first become eligible for those benefits.

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.

GUARANTEED RENEWABLE

Your coverage is Guaranteed Renewable up to the Lifetime Maximum Benefit Amount shown on your **Schedule of Benefits**. We have a limited right to change premium. 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. If your coverage terminates for any reason other than for non-payment of premium, you will have a guaranteed right to continue your coverage subject to the **CONTINUATION OF COVERAGE** provision.

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 situated. Premiums cannot be increased because of any change in the age or health of the persons covered under the policy. Written notice will be provided to the Policyholder at least 60 days in advance of any increase in premiums.

We cannot discontinue the policy except where required by law or as a result of nonpayment of premium or other causes as described in the Policy Termination section of the policy.

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.



Secretary



President

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-321-3889

You may call Unum's toll-free telephone number for information at:

1-800-331-1538

You may also write to Unum at:

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

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

1-800-252-3439

You may also write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Unum's para informacion o para someter una queja al:

1-800-321-3889

Usted puede llamar al numero de telefono gratis de Unum's para informacion al:

1-800-331-1538

Usted tambien puede escribir a Unum:

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

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU POLIZA:

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

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BENEFITS AT A GLANCE

Long Term Care Insurance

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

POLICYHOLDER: County of Travis

**POLICYHOLDER'S ORIGINAL
PLAN EFFECTIVE DATE:** April 1, 2012

POLICY NUMBER: 205655 011

ELIGIBLE GROUP(S):

All Employees, Their Spouses/Domestic Partners, and Their Family Members, Retirees and Their Family Members

Employees must be in Active Employment with the Policyholder.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For Employees in an Eligible Group on or before April 1, 2012: None

For Employees entering an Eligible Group after April 1, 2012: Each April 1st following 30 days of continuous active employment

For Employees, you must be in continuous Active Employment in an Eligible Group during the specified Waiting Period.

You will be eligible to apply during the annual enrollment period as determined by the Policyholder.

REHIRE:

If your employment ends and you are rehired within 30 days, your prior period of work while in an Eligible Group will apply toward the Waiting Period. All other policy provisions apply.

CREDIT PRIOR SERVICE:

For Employees entering an Eligible Group while continuously employed by the Policyholder, Unum will apply your prior period of work toward the Waiting Period to determine your eligibility date.

LTC FACILITY MONTHLY BENEFIT:

For eligible Employees:

\$2,000 - \$6,000 per month in \$1,000 increments

For eligible Retirees:

\$2,000 - \$6,000 per month in \$1,000 increments

For all other eligible persons:

\$2,000 - \$6,000 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:

Inflation Protection - 5% Simple

ELIMINATION PERIOD:

<loc><fname>"GLTC B@G Elim Per
Text"<efname><node>71204<enode><eloc>{{ELIM_PERIOD}}For LTC Facility or Professional Home
and Community Care Benefits: 90 accumulated days during which you were receiving this kind of
care. The Elimination Period must be satisfied within a period of 730 consecutive days. Benefits begin
the day after the Elimination Period is completed.

For Total Home Care: 90 accumulated days from the date that the chronic illness begins

WHO PAYS FOR THE COVERAGE:

For eligible Employees:

You pay the cost of your coverage.

For eligible Retirees:

You 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 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.

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: having the ability to move into or out of a bed, chair or wheelchair, or to move from one location to another, indoors and outdoors, either via walking, a wheelchair, or other means.
- Continence: the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder 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, cup or table) or by a feeding tube, or intravenously.

You will be considered able to perform the above Activities of Daily Living if you do not require the Substantial Assistance of another person to perform the ADLs.

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

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

"Adult Day Care Facility" means a provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality care requirements in the provision of Adult Day Care).

"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
- you require Substantial Supervision by another individual to protect you from threats to your health and safety due to Severe Cognitive Impairment.

"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 or Retiree.
- 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 or Retiree. A domestic partner is the person named in the Employee's or Retiree's declaration of domestic partnership. The declaration must be executed and provided to the plan administrator which gives proof that the domestic partner has had the same permanent residence as the Employee or Retiree for a minimum of 6 consecutive months prior to the date insurance would become effective for that domestic partner. The Employee or Retiree must not have signed a declaration of domestic partnership with anyone else within the last 6 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.

If a person could be eligible both as a Family Member and as an Employee or Retiree, the person is deemed to be only eligible for coverage as an Employee or Retiree.

"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 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 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**.

"Home Health Care Services" means medical or nonmedical services provided to Chronically Ill or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living, Respite Care, case management services, and maintenance or personal care services provided by a home health aide.

"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 a business that provides Home Health Care Services and is licensed by the Texas Health and Human Services Commission.

We will not recognize a Family Member as a Licensed Home Health Care Agency provider for claims that you make to us under this Policy, unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Adult Day 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 Inflation Protection increases, if applicable.

"Long Term Care Facility" (LTC Facility) means a facility (such as a nursing facility, an assisted living facility, 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.

If licensing is not required, a LTC Facility must:

- 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 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;
- 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, 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**.

"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 Health 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 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 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 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.

"Retiree" means a person who is a retired Employee of the Policyholder who is in a class of persons eligible for coverage as determined by the Policyholder and us.

"Severe Cognitive Impairment" means a severe 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 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.

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.

Retiree

If you are a Retiree of the Policyholder, you will be eligible to apply for coverage any time on or after the Policy Effective Date.

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.

Retiree, 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

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

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.

For Employees, 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 annually. 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.

TERMINATION OF BENEFITS

Your benefit payments under the policy will end on the earliest of:

- the day after you are no longer Chronically III;
- 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, subject to the notification of lapse;
- 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

If you are no longer eligible for coverage as an Employee or Retiree 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, in accordance with the **INCONTESTABILITY** provision:

- 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 two (2) years, we may rescind your coverage or deny any otherwise valid long term care insurance claim upon a showing of misrepresentation and intent to deceive in your application for insurance.

After two (2) years from the date of issue of your coverage, no misstatements, except fraudulent misstatements made by you in your application for such coverage shall be used to void your coverage or to deny a claim for loss incurred or Chronic Illness commencing after the expiration of such two-year period.

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 unless the rescission is due to your fraudulent misstatements.

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 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.

LIMITATIONS AND 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 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:

If you receive Total Choice Home Care Services during the entire month, we will pay the Total Choice Home Care benefit as shown in your **Schedule of Benefits**.

If you receive Total Choice Home Care services for less than one entire month, we will pay 1/30th of the Total Choice Home Care Monthly Benefit shown in your **Schedule of Benefits** for each day after the first day on which you are receiving Total Choice Home Care Services or until the last day on which 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.

RESPIRE 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 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.

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 four (4) 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 participation in a felony, riot or insurrection.
- 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.

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.

Payment of Additional Care Benefits will be coordinated with other insurance and/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 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 but is not limited to the following:

- 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);
- assistance with arranging a visit from a Licensed Health Care Practitioner of your choice who will develop your Plan of Care;
- a visit from a home safety expert who will evaluate 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 90 days of the date you experience a loss. 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 loss 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. 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 we may deem 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, but no more frequently than every 90 days.

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 immediately 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, such as billing you or pursuing recovery through legal action.

CLAIM DENIAL

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

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 60 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.

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 billed directly to you and/or your designated representative is the 45 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.

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 exclude any Chronic Illness by name or description except those listed in the policy under the **LIMITATIONS AND EXCLUSIONS** provision.

The time periods under the **INCONTESTABILITY** provision will apply to coverage that is reinstated under this provision, and will be measured from the reinstatement date.

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, you must provide proof that you are Chronically Ill 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 exclude any Chronic Illness by name or description except those listed in the policy under the **LIMITATIONS AND EXCLUSIONS** provision.

The time periods under the **INCONTESTABILITY** provision will apply to coverage that is reinstated under this provision, and 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.

RETURN OF PREMIUM AFTER DEATH

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

RETURN 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, return the premium paid for any period beyond the end of the month following the date of cancellation of coverage. The cancellation date will be determined as the date written notification was received by us. The return of premium will be made after we receive written notice of your cancellation request.

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 minus the total amounts of benefits already paid to you.

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 an Inflation Protection Benefit option, Return of Premium at Death option and/or Restoration of Benefits option, no 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.

INFLATION PROTECTION

If your coverage includes:

5% SIMPLE INFLATION PROTECTION

Your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date anniversary by 5% of your original LTC Facility Monthly Benefit. 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 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 5%.

In the event you decide to terminate this Inflation Protection prior to a 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% SIMPLE INFLATION PROTECTION

Your Simple Inflation Protection will terminate on the earlier of:

- the day your coverage continues under any Non-Forfeiture Benefit; or
- the day your coverage terminates as provided in the Termination of Coverage provision.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the Policy, including your Certificate of Coverage, and any additional Summary Plan Description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage, and the information in this document.

HOW TO FILE A CLAIM

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

CLAIM PROCEDURES

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

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.

Unum's Commitment to Privacy

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

Collecting Information

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

Sharing Information

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

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.

Safeguarding Information

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

Access 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 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.

Coverage Decisions

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

Contacting Us

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, 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, 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.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

MK-1883 (10-10)



UNUM'S NOTICE OF PRIVACY PRACTICES

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

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

Unum 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.

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

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

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

Uses and Disclosures of PHI for Treatment, Payment or Operations

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

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

Uses and Disclosures in Special Circumstances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Uses and Disclosures of PHI Made Only With Your Written Authorization

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

Your Rights

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

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

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

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

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

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
2211 Congress Street, C467
Portland, ME 04122

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

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.

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Effective Date of This Notice: April 14, 2003

G-73568 (06/08)

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER
THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For Insurers declared insolvent or impaired on or after September 1 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (**regardless of where the policyholder lived when the policy was issued**)
- Residents of other states, **ONLY** if the following conditions are met:
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

\$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, TX 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
800-252-3439 or www.tdi.state.tx.us