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

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Policy. The Policy is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

Policy Number: 595909

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

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

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

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

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

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

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

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Throughout this certificate:

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

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

"Policyholder" means Intermountain Healthcare, Inc. and its covered divisions, subsidiaries, and affiliated companies.

President

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SUMMARY OF BENEFITS

	Available February 1, 2005 **Active Employees, Family Members and Retirees** **At your expense**
Monthly Benefit Maximum	
Long Term Care (LTC) Facility	$1,000 to $8,000 in $1,000 increments
Assisted Living Facility	100% of the LTC Facility amount
Professional Home Care Services	100% of the LTC Facility amount
Uncapped Compound Inflation Protection	5% compounded annually
Lifetime Maximum Amount	36X the LTC Facility amount **OR** 60X the LTC Facility amount **OR** Unlimited
Elimination Period	90 consecutive days

Evidence of Insurability Limits

Evidence of insurability satisfactory to Unum is required for:

- Monthly Benefit Maximum Amount(s) greater than $7,000; or
- an Unlimited Lifetime Maximum Amount.

If Unum disapproves your evidence of insurability, you will be insured for the amount selected up to the amount that does not exceed the evidence of insurability limit(s).

CHANGES IN COVERAGE

For an Active Employee and the spouse of an Active Employee

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

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

The premium rate to be paid for any change in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the change in coverage.

For all other insured persons

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

The premium rate to be paid for any change in coverage is based on your insurance age. To determine insurance age, subtract your date of birth from the date you are applying for the change in coverage.

WHEN CHANGES IN COVERAGE WILL BE DELAYED

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

DISCRETIONARY AUTHORITY

If this plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply:

Benefits under this plan will be paid only if Unum as the claims administrator (or its designee) decides in its discretion that you are entitled to them. Unum also has discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan. This reservation of discretion by Unum does not prohibit or prevent you from seeking judicial review in federal or state court of Unum's claim determination.

The reservation of discretion made under this provision will impact the standard of review the court will apply when you seek judicial review of Unum's determination of your entitlement to benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

Unum is an insurance company that provides insurance to this benefit plan and the court will determine the level of review it will accord Unum's determinations.

TERMS YOU SHOULD KNOW

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

"**Active Employee**" means a Benefits eligible employee working for the Policyholder:

- on a full-time basis for earnings that are paid regularly;
- for a minimum of 24 hours per week; and
- at the Policyholder's usual place of business or at a location to which their job requires them to travel.

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

- BATHING - washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower with or without equipment or adaptive devices.
- DRESSING - putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- TOILETING - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- TRANSFERRING - moving into or out of a bed, chair, or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other supportive devices including mechanical or motorized devices.
- CONTINENCE - the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder functions, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- EATING - feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

"**Adult Day Care**" means a community-based program offering health, social and related support services to impaired adults. Adult Day Care can be provided by:

- a Home Health Care Provider; or
- an Adult Day Care Facility.

"**Adult Day Care Facility**" means a facility that operates under applicable state licensing laws and any other laws that apply, or meets the following tests:

- operates a minimum of 5 days a week;
- remains open for at least 6 hours a day;
- is not an overnight facility;
- maintains a written record of care on each patient;
- includes a plan of care and record of services provided;
- has a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours per day;

- has established procedures for obtaining appropriate aid in the event of a medical emergency; and

- provides a range of physical and social services to adults.

"**Assisted Living Facility**" means:

- an institution that is licensed by the appropriate licensing agency (if licensing is required) to primarily engage in providing ongoing care and services to a minimum of 3 inpatients in one location and operates under state licensing laws and any other laws that apply; or

- any other institution that meets all of the following tests:

  - provides 24 hour a day care, custodial services and personal care assistance to support needs resulting from a Disability;

  - has an employee on duty at all times who is awake, trained and ready to provide care;

  - provides 3 meals a day, including special dietary requirements;

  - operates under applicable state licensing laws and any other laws that apply;

  - has formal arrangements for the services of a Physician or nurse to furnish medical care in the event of an emergency;

  - is authorized to administer medication to patients on the order of a Physician; and

  - is not, other than incidentally, a home for the mentally retarded, the mentally ill, the blind or the deaf, a hotel or a home for alcoholics or drug abusers; or

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

- a similar institution approved by Unum.

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

- you are unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living; or

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

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

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

"**Family Members**" means:

- the legally married spouse of an Active or Retired Employee;
- the domestic partner of an Active or Retired Employee. A domestic partner is the person named in the Active or Retired Employee's declaration of domestic partnership. The Active or Retired Employee must execute and provide the plan administrator with such a declaration which states and gives proof that the domestic partner has had the same permanent residence as the Active or Retired Employee for a minimum of 12 consecutive months prior to the date insurance would become effective for that domestic partner. The Active or Retired Employee must not have signed a declaration of domestic partnership with anyone else within the last 12 months of signing the latest declaration of domestic partnership. Also, the domestic partner must be at least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named domestic partner, not married to anyone else and the declaration of domestic partnership must be approved and recorded by the plan administrator;
- the natural, adoptive or step-parents/grandparents of an Active or Retired Employee and their spouse or domestic partner;
- the natural, adoptive or step-siblings of an Active or Retired Employee and their spouse or domestic partner;
- the natural, adoptive or step-children of an Active or Retired Employee and their spouse or domestic partner.

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

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

"**Grace Period**" means the 45 days immediately following any premium due date during which premium payment must be made.

"**Home Health Care Provider**" means:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care Services will be provided;
- it is certified as a home health care organization as defined under Medicare;
- it is any other organization that meets all of the following tests:
  - primarily provides skilled nursing care and other therapeutic services;
  - has standards, policies and rules established by a professional group which is associated with the organization;
  - includes at least one Physician and one registered nurse;
  - maintains a written record of care on each patient; and
  - includes a plan of care and record of services provided; or
- a similar organization approved by Unum.

"**Hospice Care**" means a formal program of care for terminally ill patients whose life expectancy is less than 6 months, provided on an inpatient basis and directed

by a Physician in a Hospice Care Facility that is licensed, certified or registered in accordance with state law.

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

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

"**Long Term Care Facility**" means:

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

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

- licensed to practice medicine and surgery and prescribe and administer drugs; or
- legally qualified as a medical practitioner and required to be recognized, under this plan for insurance purposes, according to the insurance laws of the governing jurisdiction.

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

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

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

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

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

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

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

"**Retired Employee**" means an employee who has retired from active employment with the Policyholder.

A Retired Employee under age 81 is eligible for the plan.

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

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

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

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

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

WHEN YOU ARE ELIGIBLE FOR A MONTHLY BENEFIT

You are eligible for a Monthly Benefit after:

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

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

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

If you have an existing loss of ADLs or Severe Cognitive Impairment on your effective date of coverage, that loss or impairment will only be eligible for coverage if you recover from that loss or impairment. We must receive acceptable proof of your ADL or cognitive recovery, such as a Physician's statement or an assessment.

AMOUNT OF MONTHLY BENEFIT

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

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

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

WHEN MONTHLY BENEFITS ARE PAID

Unum will send you a lump sum payment to cover the period between the day you became eligible for monthly benefit payments and the day you were approved for these payments. Unum will then send you a payment each month for days you were eligible to receive benefits during the prior month.

WHEN MONTHLY BENEFIT PAYMENTS END

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

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

WAIVER OF PREMIUM

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

RECURRENT DISABILITY

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

RESPITE CARE BENEFITS

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

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

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

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

Respite Care may be provided to you by:

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

BED RESERVATION BENEFIT

If you are receiving a Long Term Care Facility or Assisted Living Facility monthly benefit and your stay in the Facility is interrupted because you are hospitalized, we will continue to pay the monthly benefit if a charge is made to reserve your accommodations in the Facility.

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

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

INFLATION PROTECTION

Uncapped Simple Growth Inflation Protection Option

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

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

An LTC Facility Monthly Benefit amount of $1,000 will be increased:
1. by $50 on January 1st of the next calendar year; and
2. by another $50 on each following January 1st.

CONTINGENT NONFORFEITURE BENEFIT

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

1. continue to pay the required premium;

2. lower your premium by decreasing your coverage;

3. elect to convert your coverage within 120 days of the premium increase effective date to a paid-up status with the Contingent Nonforfeiture Benefit; or

4. terminate your coverage within 120 days of the premium increase effective date and be automatically converted to the Contingent Nonforfeiture Benefit.

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

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

In no event will your Lifetime Maximum Amount:

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

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

Triggers for a Substantial Premium Increase

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

LIMITATIONS AND EXCLUSIONS

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

- a Disability caused by war (whether declared or not) or any act of war;
- a Disability caused by attempted suicide (while sane or insane) or self-destruction;
- a Disability caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law;
- Disabilities or confinements during which you are outside the United States, its territories or possessions for longer than 30 days;
- a Disability caused by alcoholism or alcohol abuse;
- a Disability caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a Physician. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.);
- a period in which you are confined in a hospital other than if you are confined in a nursing facility that is a distinctly separate part of a hospital, (this exclusion does not apply to those periods covered under the Bed Reservation Benefit)

REHABILITATION AND ALTERNATE CARE PLANS

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

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

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

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

NOTICE OF CLAIM

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

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

PROOF OF CLAIM

You must send Unum proof of claim for long term care payments no later than 90 days after the date you become Disabled. If you cannot send Unum proof within this 90-day period, you must send Unum proof as soon as it is reasonably possible to do so.

The proof of your claim must include:

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

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

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

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

Benefits payable under the policy become payable within 30 days after the receipt of proof of claim.

HOW TO FILE A CLAIM

You must fill out a Long Term Care claim form and send it to Unum. If you do not have enough information to complete the form, you may send in the Notice of Claim postcard that is attached to the claim form. The claim form must be submitted when all information is available.

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

LEGAL ACTION

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

RIGHT OF RECOVERY

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

TERMINATION OF COVERAGE

Your coverage will end on the earliest of these dates:

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

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

EXTENSION OF BENEFITS

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

CONTINUATION OF COVERAGE

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

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

Election for continued coverage must be made within 60 days from:

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

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

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

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

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

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

The premium rate schedule for continued coverage may change in the future, depending on:

- the overall use of the benefits by all insured persons; or
- changes in the benefit levels or other risk factors.

Any such change will be made on a class basis according to Unum's underwriting risk studies.

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

STATEMENTS

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

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

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

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

INCONTESTABILITY

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

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

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

UNINTENTIONAL LAPSE FOR INSURED PERSONS WHO ARE DIRECT BILLED

When you applied for coverage under the Policy you were given the opportunity to designate at least one person, in addition to yourself, who would 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. If you are an Insured Person who is direct billed, your coverage will not lapse or be terminated for nonpayment of premium unless we notify you, and those persons designated by you 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 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 the termination of your coverage.

AGENCY

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

PREMIUMS

The premium due must be paid within the Grace Period. If premium is not paid within this time, your coverage will terminate at the end of the Grace Period.

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

REINSTATEMENT

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

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

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

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

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

REINSTATEMENT OF TERMINATED COVERAGE DUE TO DISABILITY

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

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

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

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

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

POLICY RENEWABILITY

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

Additional Summary Plan Description Information

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

Name of Plan:
Intermountain Healthcare, Inc. Plan

Name and Address of Employer:
Intermountain Healthcare, Inc.
36 South State Street, Suite 1000
Salt Lake City, Utah 84111

Plan Identification Number:
a. Employer IRS Identification #: 87-0269232
b. Plan #: 516

Type of Welfare Plan:
Long Term Care

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

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address and Telephone No.:
Intermountain Healthcare, Inc.
36 South State Street, Suite 1000
Salt Lake City, Utah 84111
(801) 442-3327

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

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

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

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number/identification number 595909. Contributions to the Plan are made as stated under the Summary of Benefits in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

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

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

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

- by Unum; or
- by the Employer.

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

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

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

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

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

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

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

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

HOW TO FILE A CLAIM

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

CLAIM PROCEDURES

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

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

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

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

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

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

APPEAL PROCEDURES

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

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

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

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

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

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

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

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

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

DISCRETIONARY ACTS

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

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