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 Summary of Benefits. The Summary of Benefits is a part of the Select Group Insurance Trust situsedin Maine. Fleet Bank of Maine is the Trustee. The Summary of Benefits is intended to be a qualified Long Term Care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986. However, the policy might not be certified as a Long Term Care Policy for tax incentives under Section 5055, Title 24A of the Maine Insurance Law.

Group Identification Number: 544039

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 has 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.

- Insured persons are entitled to examine a copy of the Summary of Benefits during regular office hours at the Sponsoring Organization's place of business.
- Insured persons also are entitled to examine a copy of the Master Policy by contacting UNUM directly.
- 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:

  - **if you are an active employee or a spouse or domestic partner of an active employee**, the Sponsoring Organization's Plan Administrator,
  - **if you are a retired employee or a family member other than a spouse of an active employee**, UNUM, P.O. Box 9744, Portland, Maine 04104-9868.

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

TQC.LTC

- Throughout this certificate:

  - "you" or "your" means an active employee or a retired employee who is eligible for UNUM benefits.

    Also, "you", "your" or "family member" means:

    - the spouse of an active employee or a retired employee (you must be legally married to your spouse),
    - the domestic partner of an active employee or a retired employee,
    - the natural, adoptive or step-parents/grandparents of an active employee or a retired employee, and their spouse or domestic partner,
    - the natural, adoptive or step-siblings of an active employee or a retired employee, and their spouse or domestic partner, or
    - the natural, adoptive or step-children of an active employee or a retired employee, and their spouse or domestic partner.

  - UNUM means UNUM Life Insurance Company of America,
  - The terms "we", "our" and "us" refer to UNUM Life Insurance Company of America, and
  - Sponsoring Organization means Washington State Employees Credit Union and the following divisions, subsidiaries, and affiliated companies of Washington State Employees Credit Union:

    WECU Service Company, LLC
    Olympia, WA

President

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SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS

Eligibility and participation	You are eligible for the plan if you are an active employee or a retired employee of the Sponsoring Organization or one of the following divisions, subsidiaries or affiliated companies of the Sponsoring Organization: WECU Service Company, LLC Your family members are also eligible for the plan. Family members include your: • spouse (you must be legally married to your spouse), • domestic partner, • or your spouse's or domestic partner's natural, adoptive or step-parents/grandparents, • or your spouse's or domestic Partner's natural, adoptive or step-siblings, • or your spouse's or domestic partner's natural, adoptive or step-children. Temporary or seasonal employees are excluded.

BASE COVERAGE

- **Monthly Benefit Maximum ***

Residence Long Term Care Facility	Amounts in $1,000 units: . Minimum - 1 Unit ($1,000) . Maximum - 6 Units ($6,000)
Assisted Living Facility	An amount equal to 100% of your "Long Term Care Facility" amount.
Home or another similar place	
- Professional Home Care Services	An amount equal to 100% of your "Long Term Care Facility" amount.

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

AVAILABLE OPTIONS

- **Monthly Benefit Maximum ***

Residence Home or another similar place	
- Total Home Care	An amount equal to 100% of your "Long Term Care Facility" amount.

- **Uncapped Compound Growth Inflation Protection Option**

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

The Lifetime Maximum Amount * payable is:

24 X the "Long Term Care Facility" amount.	48 X the "Long Term Care Facility" amount.	Unlimited

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

- **Evidence of Insurability Limits**

  - Monthly Benefit Maximum Amount(s) greater than $4,000; or
  - Total Home Care coverage greater than 50% of the Long Term Care Facility amount; or
  - Unlimited Lifetime Maximum Amount.

Evidence of Insurability satisfactory to UNUM is required for amount(s) which exceed the evidence of insurability limits.

Elimination Period is 90 consecutive days.

Cost — For information, see the discussion **"WHO PAYS FOR LONG TERM CARE INSURANCE?".**

In making any benefits determination under the Summary of Benefits, UNUM will have the discretionary authority both to determine an insured person's eligibility for benefits and to construe the terms of the Summary of Benefits.

INTRODUCTION TO THE UNUM PLAN

WHAT IS THE UNUM PLAN?

The Unum plan provides long term care insurance for you.

WHAT IS LONG TERM CARE INSURANCE?

Long term care insurance gives financial help if you need care as a result of a disability.

What is meant by disability and disabled?

Disability and disabled means you are unable to perform, without substantial assistance from another individual, at least two (2) 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.

What are activities of daily living?

Activities of daily living are the activities you need to do to live independently. They are **BATHING, DRESSING, TOILETING, TRANSFERRING, CONTINENCE** and **EATING.**

- **BATHING** means 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** means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- **TOILETING** means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- **TRANSFERRING** means 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 support devices including mechanical or motorized devices.
- **CONTINENCE** means 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** means feeding yourself by getting food into your body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

What is substantial assistance?

Substantial assistance means stand-by assistance by another person without which you would not be able to safely or completely perform the activity of daily living.

What is severe cognitive impairment?

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, places 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 other forms of dementia.

What is substantial supervision?

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

WHO PAYS FOR LONG TERM CARE INSURANCE?

- **If you are an active employee,** you and the Sponsoring Organization may share the cost of your coverage under Unum's long term care insurance.
- **If you are a retired employee or a family member,** you pay the full cost of your coverage under Unum's long term care insurance.

How is the cost determined?

The premium rate to be paid over the duration of your initial coverage or for any increases is based on your insurance age.

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 of all covered 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.

How are premiums paid?

- **If you are an active employee and:**

  - the Sponsoring Organization is paying the full cost of your coverage, the premium for your coverage will be remitted by the Sponsoring Organization directly to Unum. The Sponsoring Organization will deduct premiums for your spouse's coverage from each paycheck, or

  - the Sponsoring Organization is sharing the cost of your coverage, the Sponsoring Organization will deduct your share of the premiums for your and your spouse's coverage from each paycheck.

  If you leave employment with the Sponsoring Organization, you and your spouse can continue the same coverage you each had under this plan on a direct billing basis. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group long term care insurance ends?".

- **If you are a retired employee:**

  You may have Unum direct bill you or your authorized representative for the premiums. If the Sponsoring Organization ends coverage, you and your spouse can continue the same coverage you each had under this plan. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group long term care insurance ends?".

- **If you are a family member, other than a spouse of an active employee:**

  You may have Unum direct bill you or your authorized representative for the premiums. If the Sponsoring Organization ends coverage, you can continue the same coverage you had under this plan. You pay any premium that applies for portable coverage. For more information, see the discussion: "What happens when group long term care insurance ends?".

Is there a grace period?

The Sponsoring Organization, and insured persons who are direct billed, will be allowed a grace period of 45 days after the premium due date for the remittance of each premium amount due. If such premium amount is not remitted within the grace period, coverage will terminate at the end of the grace period.

What if your coverage terminates for non-payment of premium?

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 an Application for Long Term Care Insurance; and
- we must approve the Application for Long Term Care Insurance; and
- you must pay all unpaid premium.

If your Application for Long Term Care Insurance is approved, the reinstatement will take effect on the date your group coverage was terminated for non-payment of premiums.

Reinstatement WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

What if your coverage terminates 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 reinstated coverage WILL NOT cover any disability that is excluded by name or description in the Summary of Benefits.

WILL PREMIUMS BE WAIVED WHILE YOU ARE RECEIVING A MONTHLY PAYMENT?

- **If you are receiving a "Long Term Care Facility" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to:

  - be disabled; and
  - reside in a Long Term Care Facility.

  What is a Long Term Care Facility?

  A Long Term Care Facility is:

  - 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.

What is a physician?

A physician is 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:

- you, or
- your or your family member's spouse, daughter, son, parent, sister, brother, grandparent or grandchild

as physicians for claims that you make to Unum for long term care insurance.

- **If you are receiving an "Assisted Living Facility" monthly payment:**

When benefits become payable, there will be no more cost for your coverage as long as you continue to:

- be disabled; and

- reside in an Assisted Living Facility.

What is an Assisted Living Facility?

An Assisted Living Facility is:

- 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.

- **If your plan includes the "Professional Home Care Services" Option and you are receiving a "Professional Home Care Services" monthly payment:**

When benefits become payable, there will be no more cost for your coverage as long as you continue to:

- be disabled; and
- receive Professional Home Care Services.

If you do not receive Professional Home Care Services for a period of 30 consecutive days, premium payments will again become due. To continue your coverage, premium payments **must** be resumed on the next premium due date following this 30 day period.

What are Professional Home Care Services?

Professional Home Care Services are:

- 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 1 hour or more per day of a Home Health Care Provider's services will be considered one visit;
- Adult Day Care provided by:
  - a Home Health Care Provider; or
  - an Adult Day Care Facility which operates under applicable state licensing laws and any other laws that apply; or
  - an Adult Day Care Facility which 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 a day;
    - has established procedures for obtaining appropriate aid in the event of a medical emergency; and
    - provides a range of physical and social support services to adults.
- 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.

What is hospice care?

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.

What is a licensed health care practitioner?

A 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.

Professional Home Care Services do not include services performed by your family members' spouse, daughter, son, parent, grandparent or grandchild through a Home Health Care Provider or an Adult Day Care facility.

What is a Home Health Care Provider?

A Home Health Care Provider is:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care Services will be provided;
- certified as a home health care organization as defined under Medicare;
- 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.

- **If your plan includes the "Total Home Care" Option and you are receiving a "Total Home Care" monthly payment:**

When benefits become payable, there will be no more cost for your coverage as long as you continue to be disabled.

What is Total Home Care?

Total Home Care provides financial help in case you need care at home or another similar place due to a disability.

Total Home Care 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;
- Adult Day Care;
- Hospice Care; or
- care provided by an informal caregiver, such as your friends or relatives.

The treatment and services you receive must be provided pursuant to a written plan of care developed by a licensed health care practitioner.

What is Adult Day Care?

Adult Day Care means care provided by a licensed Home Health Care Provider or an Adult Day Care Facility in a community-based group program offering health, social and related support services to impaired or disabled adults.

What is an Adult Day Care Facility?

Adult Day Care Facility is a facility that provides Adult Day Care and operates under state licensing laws and any other laws that apply; or meets the following tests:

- Operate a minimum of 5 days a week;
- Remain open for at least 6 hours a day;
- Not be an overnight facility;
- Maintain a written record of care on each patient;
- Include a plan of care and record of services provided;
- Have 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 a day;
- Have established procedures for obtaining appropriate aid in the event of a medical emergency; and
- Provide a range of physical and social support services to adults.

What is a Home Health Care Provider?

A Home Health Care Provider is:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care Services will be provided;
- certified as a home health care organization as defined under Medicare;
- 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.

What is hospice care?

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.

What is a licensed health care practitioner?

A 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.

WHO IS ELIGIBLE FOR THE PLAN?

Persons who may be eligible for the plan are:

Active or retired employees of the Sponsoring Organization and their family members.

What is an active employee?

An active employee means that you are working for the Sponsoring Organization:

- on a full-time basis for earnings that are paid regularly,
- for a minimum of 20 hours each week, and
- at the Sponsoring Organization's usual place of business, or
- at a location to which your job requires you to travel.

Temporary or seasonal employees are excluded.

What is a retired employee?

A retired employee means that you are at least 65 years of age, or at least 55 years of age and have been employed with WSECU for 15 or more years just prior to your retirement date.

A retired employee under age 85 is eligible for the plan.

What is a family member?

A family member means:

- the spouse of an active employee or a retired employee (you must be legally married to your spouse),
- the domestic partner of an active employee or a retired employee,
- the natural, adoptive or step-parents/grandparents of an active employee or a retired employee,
- the natural, adoptive or step-parents/grandparents of a spouse or domestic partner of an active employee or a retired employee,
- the natural, adoptive or step-siblings of an active employee or a retired employee, and their spouse or domestic partner, or
- the natural, adoptive or step-children of an active employee or a retired employee, and their spouse or domestic partner.

A domestic partner is the person named in the Active Employee's declaration of domestic partnership. The Active 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 Employee for a minimum of 12 consecutive months prior to the date insurance would become effective for that domestic partner. The Active 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.

To be eligible for coverage, family members must be between the ages of 18 and 85.

IF YOU ARE AN ACTIVE EMPLOYEE, WHEN ARE YOU ELIGIBLE FOR LONG TERM CARE COVERAGE, WHEN AND HOW DO YOU APPLY?

When do you become eligible?

You must be in an eligible class continuously for a certain period of time before you will be eligible for coverage. This period of time is called the waiting period.

If you are in an eligible class on or before December 1, 1999, there is no waiting period. You will be eligible for coverage on December 1, 1999.

If you enter an eligible class after December 1, 1999, the waiting period is a period ending on the first day of the month that follows date of active employment. You will be eligible for coverage on the date you complete the waiting period.

If you are an active employee, when MUST you apply for coverage?

You **must** apply for coverage for which you will be charged a premium.

You **do not** need to apply for coverage for which the Sponsoring Organization pays the full cost.

For more information, see the discussion: **"WHO PAYS FOR LONG TERM CARE INSURANCE?".**

When can you apply for coverage?

- **If you are an active employee:**

  The period of time beginning on the date you become eligible for coverage and ending 30 days after that date is called your first enrollment period. The annual enrollment period is a period chosen by your Employer.

  - **During your first enrollment period or during the first annual enrollment period that occurs following the date you become eligible to apply,** you can apply for coverage without evidence of insurability for amounts that **do not** exceed evidence of insurability limits. Evidence of insurability will be required if you are applying for coverage amounts that **do** exceed the evidence of insurability limits, as shown on the SCHEDULE OF LONG TERM CARE BENEFITS.

  - **During subsequent enrollment periods,** you can apply for coverage with evidence of insurability.

- **If you are the spouse of an active employee::**

  You can apply for coverage, with evidence of insurability, any time after the date you become eligible for coverage.

- **If you are a retired employee:**

  You can apply for coverage, with evidence of insurability, any time after the date you become eligible for coverage.

How do you apply for coverage?

- **If you are an active employee:**

  - **During your first enrollment period:**

    You can apply for coverage by filling out a Benefit Elections Form.

    If you do not already have a Benefit Elections Form, you can get one from your Plan Administrator or Unum representative.

    After you fill out the Benefit Elections Form, be sure you sign and date it. The Benefit Elections Form will not be valid unless you sign and date it.

    Send the completed Benefit Elections Form to your Plan Administrator or directly to Unum to the address provided to you.

  - **After your first enrollment period:**

You can apply for coverage by filling out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from your Plan Administrator or Unum representative.

Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability that it requests.

After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

Send the completed Benefit Elections Form and Application for Long Term Care Insurance to your Plan Administrator or directly to Unum to the address provided to you.

- **If you are the spouse of an active employee:**

  You can apply for coverage by filling out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from your Plan Administrator or directly from Unum at the address provided to you.

  Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

  After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

  Send the completed Benefit Elections Form and Application for Long Term Care Insurance to your Plan Administrator or directly to Unum to the address provided to you.

- **If you are a retired employee:**

  You can apply for coverage by filling out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from your Plan Administrator or directly from Unum at the address provided to you.

  Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

  After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

  Send the completed Benefit Elections Form and Application for Long Term Care Insurance to your Plan Administrator or directly to Unum to the address provided to you.

What is evidence of insurability?

Evidence of insurability includes not only the information you supply on the Application for Long Term Care Insurance, but also may include other proof of your medical history such as test results, medical exams, physicians' statements, etc. Unum may also request that an insurability assessment be performed. Unum will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or reject an Application for Long Term Care Insurance.

What is an insurability assessment?

An insurability assessment means a review done by Unum or its designated representative to help in evaluating your cognitive and functional status. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by Unum or its designated representative.

IF YOU ARE A FAMILY MEMBER, WHEN ARE YOU ELIGIBLE FOR LONG TERM CARE COVERAGE, WHEN AND HOW DO YOU APPLY?

When do you become eligible?

You will be eligible for coverage on the date the employee is eligible for coverage.

If you are eligible for coverage as an active employee or a retired employee, you are only eligible for coverage as an employee.

When can you apply for coverage?

You can apply for coverage any time after the date you become eligible for coverage.

How do you apply for coverage?

To apply for coverage, you must fill out a Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability. If you do not already have a Benefit Elections Form and/or an Application for Long Term Care Insurance, you can get one from Unum at the address provided to you.

Unum will pay any of the costs that it views as necessary to obtain any evidence of insurability it requests.

After you fill out the Benefit Elections Form and Application for Long Term Care Insurance, be sure you sign and date them. The Benefit Elections Form and Application for Long Term Care Insurance will not be valid unless you sign and date them.

Send the completed Benefit Elections Form and Application for Long Term Care Insurance directly to Unum to the address provided to you.

What is evidence of insurability?

Evidence of insurability includes not only the information you supply on the Application for Long Term Care Insurance, but also may include other proof of your medical history such as test results, medical exams, physicians' statements, etc. Unum may also request that an insurability assessment be performed. Unum will use the medical history as well as information obtained through any insurability assessment to help decide whether to accept or reject an Application for Long Term Care Insurance.

What is an insurability assessment?

An insurability assessment means a review done by Unum or its designated representative to help in evaluating your cognitive and functional status. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by Unum or its designated representative.

WHEN DOES COVERAGE BEGIN?

- **If you are an active employee:**
  - **Coverage for which you did not need to apply** will begin on the later of these dates:
    - the plan effective date, or
    - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which you become eligible for coverage.
  - **Coverage applied for within your first enrollment period that does not exceed Evidence of Insurability limits** will begin on the latest of these dates:
    - the plan effective date,
    - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which you become eligible for coverage, or
    - 12:01 a.m. on the first day of the month that occurs on or next follows the date you applied for coverage.
  - **Coverage applied for within your first enrollment period that does exceed Evidence of Insurability limits** will begin on the later of these dates:
    - the plan effective date if Unum approves your Application for Long Term Care Insurance on or before that date, or
    - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which Unum approves your Application for Long Term Care Insurance.

- **Coverage applied for after your first enrollment period** will begin at 12:01 a.m. on the first day of the month that occurs on or next follows the month in which Unum approves your Application for Long Term Care Insurance.

- **If you are a retired employee or a family member:**

  Coverage applied for will begin on the later of these dates:

  - the plan effective date if Unum approves your Application for Long Term Care Insurance on or before that date, or

  - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which Unum approves your Application for Long Term Care Insurance.

What if you are an active employee and absent from work on the date your coverage would normally begin?

Coverage will not begin for you 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.

The coverage will begin at 12:01 a.m. on the date you return to work as an active employee.

What if you are a retired employee or a family member and you are totally disabled on the date your coverage would normally begin?.

Coverage will not begin for you if you are totally disabled on the date that the coverage would normally begin.

The coverage will begin at 12:01 a.m. on the date that you no longer are totally disabled.

What does Unum mean by totally disabled if you are a retired employee or a family member?

You are totally disabled if, because of an injury or a sickness, you are unable to perform each of the duties or activities of a person of the same age and sex in good health.

What if the Sponsoring Organization rehires you?

Usually, you must be in an eligible class continuously for the length of the waiting period in order to become eligible for coverage.

However, if:

- you used to work for the Sponsoring Organization, and
- the Sponsoring Organization hires you again within one year from the date your employment ended,

Unum will count as part of the waiting period the time you were in an eligible class before your employment ended.

CAN COVERAGE BE CHANGED?

You can apply at any time to change coverage by filling out a new Benefit Elections Form and an Application for Long Term Care Insurance.

When will the changes take effect?

The changes will take effect at 12:01 a.m. on the first day of the month that occurs on or next follows the month in which Unum approves your Application for Long Term Care Insurance.

Increases in the amount of insurance coverage will not take effect on the date they would normally take effect if:

- you are an active employee of the Sponsoring Organization and you are absent from work on that date because you are injured, sick, temporarily laid off or on a leave of absence, or
- you are a retired employee or a family member and you are totally disabled on that date.

The increase or addition in insurance coverage will take effect at 12:01 a.m. on the date:

- you, an active employee of the Sponsoring Organization, return to work as an active employee, and
- you, a retired employee or a family member, no longer are totally disabled.

WHEN WILL GROUP COVERAGE THROUGH THE PLAN END FOR YOU?

When will coverage end?

Your coverage will end on the latest of these dates:

- the date the Summary of Benefits under the policy ends,
- the date you no longer are in an eligible class,
- the date your class no longer is included for insurance,
- the date your total benefit payments equal your Lifetime Maximum Amount,
- the end of the period for which premiums were last remitted to Unum for your coverage,
- the date you no longer are an active employee with the Sponsoring Organization, or
- the date you die.

In most cases, however, you may continue coverage after the coverage would normally end. For more information, see the discussion: "What happens when group long term care coverage ends?".

What if you are absent from work at Washington State Employees Credit Union?

If you are absent from work for any reason, you will continue to be covered for group coverage if the Sponsoring Organization continues to remit to Unum the premium for the coverage.

What happens when group long term care coverage ends?

If group long term care coverage ends, you or your authorized representative may elect portable coverage for you. This means that the same coverage you had under this plan can continue on a direct billing basis. Retired employees and any other persons who are direct billed will automatically transfer to portable coverage.

But, if your group long term care coverage ends because you chose to have premium payments stopped for your coverage, you may not elect portable coverage.

Any election for portable coverage must be made within 60 days of the date the group coverage would otherwise end. If so elected, you are a portable insured.

Any premium that applies must be paid directly to Unum by you for any portable coverage to be continued.

Also, the premium rate schedule for portable coverage may change in the future, depending on the overall use of the benefits by all covered 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.

Can coverage be changed once on portability?

You can apply at any time to increase coverage by filling out a new Benefit Elections Form and an Application for Long Term Care Insurance which includes evidence of insurability.

LONG TERM CARE INSURANCE

WHAT ARE LONG TERM CARE BENEFITS?

A long term care benefit will be paid to you if you become disabled according to the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS. The amount of the monthly payment will depend on:

- the long term care plan of coverage you choose;
- any options you choose, if available;
- the place of residence used for long term care; and
- if your claim is for a "Professional Home Care Services" monthly benefit, the number of days of Professional Home Care Services you receive each month.

What is the Lifetime Maximum Amount you can receive under the Summary of Benefits?

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

The Lifetime Maximum Amount under the Summary of Benefits for this certificate is shown in the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS.

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

HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?

You will qualify to receive monthly payments from Unum 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 Services benefit; or Total Home Care if your plan includes a Total Home Care benefit;
- you have satisifed your Elimination Period; and
- a physician has certified that you are unable to perform (without substantial assistance from another individual) two or more ADLs for a period of at least 90 days, or that you require substantial supervision by another individual to protect you and others from threats to health or safety due to severe cognitive impairment. You will be required to submit a physician certification every 12 months.

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 ADL loss or severe cognitive impairment on your effective date of coverage, that loss or impairment will be eligible for coverage only 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.

What is the Elimination Period?

The Elimination Period is the number of consecutive days during which you must continue to qualify to receive long term care monthly payments before benefits can become payable. For information on how to qualify to receive long term care monthly payments see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?"**.

However, if your plan includes the "Professional Home Care Services" Option and you are receiving "Professional Home Care Services", each calendar week that you receive at least one day of Professional Home Care Services will be counted as seven days towards completing the Elimination Period.

If you continue to remain at home or another similar place and do not receive Professional Home Care Services for at least one day within a calendar week, the Elimination Period will begin again.

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

The Elimination Period under the Summary of Benefits for this certificate is shown in the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS.

WHEN WILL YOU RECEIVE MONTHLY PAYMENTS FOR LONG TERM CARE?

You will receive monthly payments from Unum once you qualify. For information on how to qualify to receive long term care monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?"**.

HOW MUCH WILL UNUM PAY IF YOU HAVE A DISABILITY?

If you have a disability and qualify to receive monthly payments, Unum will send the payment to you each month. The amount of the monthly payment will be based on the plan(s) and option(s), if available, that you have chosen from the SCHEDULE OF LONG TERM CARE INSURANCE BENEFITS. See your CONFIRMATION FORM to determine the amount Unum will pay you each month.

- **If you qualify for a "Long Term Care Facility" payment for a period that is less than one month,** Unum will pay 1/30th of your "Long Term Care Facility" Monthly Benefit Maximum for each day that you:
  - are disabled; and
  - reside in a Long Term Care Facility.

- **If you qualify for an "Assisted Living Facility" payment for a period that is less than one month,** Unum will pay 1/30th of your "Assisted Living Facility" Monthly Benefit Maximum for each day that you:

  - are disabled; and

  - reside in an Assisted Living Facility.

- **If your plan includes the "Professional Home Care Services" option and you qualify for a "Professional Home Care Services" payment for a period that is less than one month,** Unum will pay 1/30th of your "Professional Home Care Services" Monthly Benefit Maximum for each day that you:

  - are disabled; and

  - receive Professional Home Care Services.

- **If your plan includes the "Total Home Care" option and you qualify for a "Total Home Care payment for a period that is less than one month,** Unum will pay 1/30th of your "Total Home Care" Monthly Benefit Maximum for each day that you are disabled.

For information on how to qualify to receive monthly payments, see the discussion **"HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?".**

HOW LONG WILL UNUM CONTINUE TO PAY YOU FOR LONG TERM CARE BENEFITS?

Unum will continue monthly payments to you for long term care benefits until the earliest of the following dates:

- the expiration of your physician certification,
- the date you no longer are disabled,
- the date you die,
- the date you no longer qualify to receive a monthly payment under the long term care plan of coverage you chose, or
- the date your total benefit payments equal the Lifetime Maximum Amount.

CAN LONG TERM CARE BENEFITS BE INCREASED TO PROTECT AGAINST INCREASING COST?

Yes.

- **If you choose the uncapped Compound Growth Inflation Protection Option at the time of enrollment,** your initial amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your amount of coverage in effect on the last day of the previous calendar year.

- **If you choose the uncapped Compound Growth Inflation Protection Option when you apply for additional coverage,** your additional amount of coverage will be increased by 5% on January 1st of the next calendar year. Subsequent 5% increases will be added, each January 1st after that, to your ad-

ditional amount of coverage in effect on the last day of the previous calendar year.

- **FOR EXAMPLE:** A monthly benefit amount of $1,000 will be increased by 5% of $1,000 for an amount of coverage equal to $1,050 for the next calendar year; 5% of $1,050 for an amount of coverage equal to $1,103 for the following calendar year; and so on.

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

No inflation increases will be made after the end of the period for which premiums were last remitted to Unum for your coverage.

CAN YOU RECEIVE ANY PAYMENTS WHILE YOU ARE RECEIVING RESPITE CARE IF UNUM IS NOT YET MAKING LONG TERM CARE MONTHLY PAYMENTS?

Yes. If you qualify for a Home or another similar place monthly 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

Unum will make payments to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your Home or another similar place Monthly Benefit Maximum for each day that you receive respite care. Payments made to you for respite care will reduce your Lifetime Maximum Amount under the Summary of Benefits.

You **do not** have to complete the Elimination Period for respite care payments to become payable.

Premiums are **not** waived while you are receiving a payment for respite care.

What is respite care?

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

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,or
- an informal caregiver such as a friend or relative.

WHAT IF YOU BECOME DISABLED AGAIN AFTER RECEIVING LONG TERM CARE PAYMENTS FROM UNUM?

If you become disabled again after Unum stopped making long term care payments to you for the previous loss, you **do not** have to satisfy a new Elimination Period. Unum will pay long term care benefits to you until the earliest of the dates listed in the discussion **"HOW LONG WILL UNUM CONTINUE TO PAY YOU FOR LONG TERM CARE BENEFITS?"**.

WHAT IS NOT COVERED FOR LONG TERM CARE?

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

- disabilities caused by war (whether declared or not) or any act of war,
- disabilities caused by attempted suicide (while sane or insane) or self-destruction,
- disabilities 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,
- any days over fifteen days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- disabilities caused by alcoholism, or
- disabilities 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.).

WILL UNUM MAKE ANY PAYMENT TO YOU IF YOU HAD A CONDITION BEFORE UNUM'S LONG TERM CARE COVERAGE BEGINS?

Unum will not make any payments to you during the first six months after your coverage begins for any disability that:

- is caused by, contributed to by, or results from a pre-existing condition, and
- begins during the first six months after your coverage begins.

A pre-existing condition is any condition that exists for which you:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition,

during the six month period right before your coverage began.

This pre-existing conditions limitation will apply to all insurance that does not require evidence of insurability.

Note: A pre-existing condition is not the same as a loss of ADLs or severe cognitive impairment that existed before your effective date of coverage.

If you have a **loss** of ADLs or severe cognitive **impairment** before your effective date of coverage, that **loss** or **impairment** will never be covered.

If you have a **condition** that exists prior to your effective date of coverage that has not resulted in a loss of ADL or impairment, that condition may be a pre-existing condition. If it is a pre-existing condition and you have a **loss** of 2 or more ADLs or severe cognitive impairment caused by, contributed to by or resulting from that pre-existing condition during the first 6 months **after your effective date of coverage,** these losses or impairment will not be covered until your seventh month of coverage.

CAN UNUM HELP YOU REGAIN THE ABILITY TO INDEPENDENTLY PERFORM THE ACTIVITIES OF DAILY LIVING?

While you are disabled, Unum may suggest an alternate care plan designed to help you regain the ability to independently perform the activities of daily living. The alternate care plan may be special services and/or equipment that are medically necessary and appropriate for your disability and provided pursuant to a written plan of care developed by a licensed health care practitioner. The services or equipment must be intended to assist you at home or in 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 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 Summary of Benefits.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS INSURANCE BE USED?

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. 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.

Unum can take these actions only in the first 2 years your initial coverage or changes in coverage is in force.

CAN UNUM RESCIND COVERAGE OR DENY A VALID LONG TERM CARE CLAIM FOR MISREPRESENTATION?

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.

CAN THE SPONSORING ORGANIZATION ACT AS UNUM'S AGENT?

For all purposes of the Summary of Benefits, the Sponsoring Organization acts on its own behalf or as the employee's agent. Under no circumstances will the Sponsoring Organization be deemed Unum's agent.

IS THE SUMMARY OF BENEFITS GUARANTEED RENEWABLE?

The Summary of Benefits is guaranteed renewable on each Anniversary Date.

What does Unum mean by Guaranteed Renewable?

Guaranteed renewable means that the Summary of Benefits will continue in force subject to the following conditions:

- the Sponsoring Organization promptly gives Unum any information that Unum requires,
- the Sponsoring Organization performs all of its obligations that relate to the Summary of Benefits, and
- the Sponsoring Organization continues to remit all premiums due within the grace period.

CLAIM INFORMATION

WHEN DO YOU FILE A CLAIM FOR LONG TERM CARE PAYMENTS?

Written notice of a claim must be given within 30 days after the date that your disability began or as soon as it is reasonably possible to do so.

If you do not have a Long Term Care Notice of Claim Form, you can get one from the Sponsoring Organization'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.

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

The proof of your claim must include:

- the date your disability occurred;
- the cause of your disability;
- the extent of your disability;
- certification by a physician 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 or 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 proof of continued disability within this 30-day period, it must be given as soon as reasonably possible. However, proof of continued disability must be given no later than one year after the time proof is otherwise required.

If your plan includes the "Professional Home Care Services" Option, and your claim is for a "Professional Home Care Services" monthly payment, Unum must also receive proof of the Professional Home Care Services provided to you.

HOW DO YOU FILE A CLAIM FOR LONG TERM CARE PAYMENTS?

You or your authorized representative must fill out, detach and mail the Notice of Claim postcard to Unum. This postcard is provided as an attachment to the Long Term Care Claim Form.

You or your authorized representative must also fill out the Long Term Care Claim Form and send it to Unum. If you have enough information to fully complete and send the Long Term Care Claim Form, you do not need to send the Notice of Claim postcard separately.

Once Unum receives the Notice of Claim postcard and/or the Long Term Care Claim Form, a Claims Representative will contact you or your authorized representative to review the information on the form(s) and answer any questions you may have.

As part of proof of claim, Unum may request that a claims assessment be performed.

Unum may also send your attending physician(s) a Long Term Care Attending Physician's Initial Statement Form to fill out and send to Unum. In some cases, Unum may require additional Attending Physician's Progress Statements if you continue to be disabled.

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 it authorization to obtain additional medical and nonmedical information as part of the proof of claim.

What is a claims assessment?

A claims assessment means a review done by Unum or its designated representative to help in evaluating the status of your disability. It may include:

- a telephone interview with you; and/or
- a face-to-face interview with you at a location selected by Unum or its designated representative.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or an authorized representative may not sue on your claim before 60 days after proof of loss has been given to Unum. You or an authorized representative may not sue after 3 years from the time proof of loss is required.

WHEN WILL UNUM BEGIN TO SEND YOU LONG TERM CARE PAYMENTS?

When Unum receives acceptable proof of your claim for long term care payments, Unum will begin to send you long term care payments if you qualify. For more information on how to qualify for long term care monthly payments, see the discussion "HOW DO YOU QUALIFY TO RECEIVE LONG TERM CARE MONTHLY PAYMENTS?".

Unum will send you a lump sum payment to cover the period of time between the day you became eligible for benefit payments and the day you were approved for benefit payments. Unum will then send you a payment each month during any remaining period you are disabled for which you are eligible to receive long term care payments. For information about how long Unum will continue to send long term care payments, see **"HOW LONG WILL UNUM CONTINUE TO PAY FOR LONG TERM CARE BENEFITS?".**

HOW DOES UNUM'S RIGHT OF RECOVERY AFFECT YOUR CLAIM?

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

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

If this Summary of Benefits 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 Summary of Benefits, including your Certificate of of Coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the Summary of Benefits, 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 Summary of Benefits unless a shorter time period is stated in the Summary of Benefits.

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 Summary of Benefits.

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 Summary of Benefits.

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 Summary of Benefits 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 Sponsoring Organization 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.