



## **ENSIGN SERVICES INCORPORATED**

### Group Critical Illness - Voluntary

Policy No. R0096446

All Other Employees

Underwritten by Unum Life Insurance Company of America

December 4, 2013

## CERTIFICATE OF COVERAGE

**THIS IS A LIMITED BENEFIT CERTIFICATE OF COVERAGE. PLEASE READ IT CAREFULLY.**

**THIS IS A SUPPLEMENT TO BASIC HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT, OR MAJOR MEDICAL EXPENSE INSURANCE.**

You must write Your name in the space provided when You receive this certificate so that it becomes Your Certificate of Coverage. Your coverage effective date is described in the General Provisions section.

Name: \_\_\_\_\_

Unum Life Insurance Company of America (referred to as Unum) welcomes You as a client.

This is Your Certificate of Coverage as long as You are eligible for coverage and You become insured. You will want to read it carefully and keep it in a safe place.

Unum has written Your Certificate of Coverage in plain English. However, a few terms and provisions are written as required by insurance law. If You have any questions about any of the terms and provisions, please consult Unum. Unum will assist You in any way to help You understand Your benefits.

If the terms and provisions of this Certificate of Coverage (issued to You) are different from the policy (issued to the Policyholder), the policy will govern. The policy may be changed in whole or in part. Only an officer of Unum can approve a change. The approval must be in writing and endorsed on or attached to the policy. Any other person, including a broker, may not change the policy or waive any part of it.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

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

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

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**BENEFITS AT A GLANCE  
CRITICAL ILLNESS**

This Critical Illness Policy provides financial protection for You by paying a benefit if You are diagnosed with a critical illness. The amount You receive is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy. You also have the opportunity to have coverage for Your Spouse.

**EMPLOYER'S ORIGINAL POLICY**

**EFFECTIVE DATE:** January 1, 2014

**POLICY NUMBER:** R0096446 GCI\_EE\_PAY-02

**ELIGIBLE GROUP(S):**

All Other Employees in Active Employment in the United States with the Employer.

**MINIMUM HOURS REQUIREMENT:**

Employees must be in Active Employment at least 32 hours per week.

**PAYING FOR COVERAGE:**

**For You:**

You must make contributions for Your coverage.

Coverage on Your eligible Dependent Children is automatically included with Your coverage.

**For Your Spouse:**

You must make contributions for coverage for Your Spouse.

**CRITICAL ILLNESS BENEFIT**

**Coverage Amount**

Employee:	\$5,000 - \$50,000 in \$1,000 increments as applied for by You and approved by Unum.
Spouse, if Covered:	\$5,000 - \$30,000 in \$1,000 increments as applied for by You and approved by Unum.
Dependent Child(ren):	25% of Employee Coverage Amount

<b>Critical Illnesses</b>	<b>Percentage of Coverage Amount</b>
<b><u>Base Covered Conditions</u></b>	
<b>Benign Brain Tumor</b> Initial Diagnosis Benefit	100%
<b>Blindness</b> Initial Diagnosis Benefit	100%
<b>Coma as the Result of Severe Traumatic Brain Injury</b> Initial Diagnosis Benefit	100%
<b>Coronary Artery Bypass Surgery</b> Initial Diagnosis Benefit	25%
<b>End Stage Renal (Kidney) Failure</b> Initial Diagnosis Benefit	100%

<b>Heart Attack (Myocardial Infarction)</b> Initial Diagnosis Benefit	100%
<b>Major Organ Failure</b> Initial Diagnosis Benefit	100%
<b>Permanent Paralysis as the result of a Covered Accident</b> Initial Diagnosis Benefit	100%
<b>Stroke</b> Initial Diagnosis Benefit	100%
<b><u>Cancer Conditions</u></b>	
<b>Cancer</b> Initial Diagnosis Benefit	100%
<b>Carcinoma in Situ</b> Initial Diagnosis Benefit	25%
<b><u>Additional Critical Illnesses for Dependent Children</u></b>	
<b>Cerebral Palsy</b> Initial Diagnosis Benefit	100%
<b>Cleft Lip or Palate</b> Initial Diagnosis Benefit	100%
<b>Cystic Fibrosis</b> Initial Diagnosis Benefit	100%
<b>Down Syndrome</b> Initial Diagnosis Benefit	100%
<b>Spina Bifida</b> Initial Diagnosis Benefit	100%

**Critical Illness Benefit Reduction**

Any coverage in force prior to the Insured's 70th birthday will be reduced on the Policy Anniversary Date following the Insured's 70th birthday. The Insured's Coverage Amount will be reduced to 50% of the Coverage Amount the Insured had prior to the Policy Anniversary Date. Any coverage in force after the Policy Anniversary Date following the Insured's 70th birthday will not be subject to a benefit reduction on subsequent Policy Anniversary Dates. There will be no further increases in the Insured's Coverage Amount.

**WELLNESS BENEFIT**

**Wellness Benefit Amount** \$50 per Calendar Year for each Insured

**BENEFIT PLAN COVERAGE CHOICES:**

You may select one of the following plans:

**Benefit Plan 1:**

Base Covered Conditions with Additional Critical Illnesses for Dependent Children; and Wellness Benefit

**Benefit Plan 2:**

Base Covered Conditions with Additional Critical Illnesses for Dependent Children; Cancer Conditions; and Wellness Benefit

**SOME LOSSES MAY NOT BE COVERED UNDER THIS POLICY.**

## **OTHER FEATURES**

Portability

**The above items are only highlights of this Policy. For a full description of Your coverage, continue reading Your Certificate of Coverage and if You make contributions for Your coverage, refer to Your confirmation of coverage. The plan includes enrollment, risk management and other support services related to Your Employer's benefit program.**

## CLAIM INFORMATION

**Notice of Claim.** Notice of claim should be sent to Unum within 90 days after the Date of Diagnosis for which a benefit is claimed or the date of Covered Loss for which a benefit is claimed, or as soon as is reasonably possible. If notice is not reasonably possible to provide within 90 days, it must be given no later than one year after the time notice of claim is required. These time limits will not apply during any time period You or Your authorized representative lacks the legal capacity to give Unum notice of claim. Notice should be sent to Unum at Our home office. If You submit a claim before notification of Unum's decision on any coverage amount requiring Evidence of Insurability, the amount of coverage applicable to the claim will be determined as if Unum's final underwriting decision had been made prior to the Date of Diagnosis or date of Covered Loss.

**Claim Forms.** When Unum receives a notice of claim, claim forms will be sent for filing proof of claim within 15 days. If claim forms are not sent within 15 days, the proof of claim requirements will be met if We receive a written statement of the nature and extent of the loss as required in the proof of claim section. Claim forms are also available from Your Employer.

**Proof of Claim.** Proof of claim must include documentation furnished by a Physician and supported by clinical, radiological, histological, pathological, and/or laboratory evidence. It may also include one or more of the following: a Physician's bill, a Hospital bill, or other proof of charges.

If it is not reasonably possible to give proof of claim within 90 days after the Date of Diagnosis for which a benefit is claimed or date of Covered Loss for which a benefit is claimed, it must be given no later than one year after the time proof of claim is required. These time limits will not apply during any time period the Insured or the Insured's authorized representative lacks the legal capacity to give Unum proof of claim.

**Time of Payment of Claims.** After Unum receives, evaluates and processes proof of claim, Unum will pay any benefits due.

**Payment of Claims.** Benefits will be paid to You unless such benefits have been assigned. If You are not competent, Unum can pay up to \$2,000 to the person or institution that appears to have assumed Your custody and main support. Any accrued benefits unpaid at Your death will be paid to the named beneficiary, if any, otherwise to Your estate. Unum will be discharged to the extent of any such payment made in good faith.

**Overpayments.** Unum has the right to recover any overpayments due to:

- fraud; and
- any error We make in processing a claim.

You must reimburse Us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount We paid You.

**Unpaid Premium.** Any unpaid premium due for Your coverage under this policy may be recovered by Us by offsetting against amounts otherwise payable to You, Your

beneficiary, or Your legal representative(s) under this policy, or by other legally permitted means.

**Assignment.** The rights provided to You by the policy are owned by You, unless You assign Your rights under the policy to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by You, and acceptable to Us in form; and
- a signed or certified copy of the written assignment has been received and registered by Us at Our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the policy provisions before receiving and registering an assignment.

**Physical Examinations and Autopsy.** We can require that the Insured be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while a claim is pending. In case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**Legal Actions.** You or Your authorized representative can start legal action regarding Your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim was first required to have been given; or Your claim was denied; or Your benefits were terminated, unless otherwise provided under federal law.



## **GENERAL PROVISIONS**

### **ELIGIBILITY FOR COVERAGE**

#### **Employee**

If You are working for Your Employer in an eligible group, You are eligible for coverage on the later of:

- the Policy Effective Date; or
- the day after You complete any applicable Eligibility Waiting Period.

If Your employment ends and You are rehired within 12 months, Your previous work in an eligible group will apply toward the Eligibility Waiting Period. All other policy provisions apply.

Unum will apply any period of work with Your Employer toward the Eligibility Waiting Period to determine Your eligibility date.

#### **Dependent Children**

If You are covered under this policy, Your Dependent Children are automatically eligible for coverage on the later of:

- the date Your coverage begins; or
- the date You first acquire the Dependent Child.

#### **Spouse**

If You are covered under this policy, Your Spouse is eligible for coverage on the later of:

- the date Your coverage begins; or
- the date You first acquire a Spouse.

You may not apply for coverage for Your Spouse if Your Spouse is covered as an Employee.

### **COVERAGE EFFECTIVE DATE**

You may apply at Enrollment for coverage based on the benefits available as shown in the Benefits at a Glance. When You apply for coverage or are covered under this policy, You are also eligible to apply for coverage on your Spouse. Evidence of Insurability may be required.

The Insured's coverage will begin at 12:01 a.m. on the date shown on the confirmation of coverage, provided Unum has approved Your application and any required Evidence of Insurability.

If You are absent from work due to Injury, Sickness, temporary Layoff or Leave of Absence on the date Your coverage would normally begin, the proposed Insured's coverage will begin on the date You return to Active Employment.

## **Replacement of Coverage with Prior Carrier**

If, within 31 days of the Policy Effective Date, You are replacing similar coverage You had in force through Your Employer sponsored individual policy, Evidence of Insurability is not required for amounts of coverage You had in force with Your Employer's prior carrier on the termination date of the prior carrier's plan up to \$50,000. Evidence of Insurability may be required for coverage in excess of the insurance You had in force under the prior policy.

If, within 31 days of the Policy Effective Date, You are replacing similar Spouse coverage You had in force through Your Employer sponsored individual policy, Evidence of Insurability is not required for amounts of Spouse coverage You had in force with Your Employer's prior carrier on the termination date of the prior carrier's plan up to \$30,000. Evidence of Insurability may be required for coverage in excess of the insurance You had in force under the prior policy.

**Changes You Make to Your Coverage.** If changes in coverage are allowed, You may choose to:

- increase coverage based on the available benefits shown in the Benefits at a Glance;
- decrease coverage based on the available benefits shown in the Benefits at a Glance; or
- cancel coverage.

Evidence of Insurability may be required.

Changes in coverage begin at 12:01 a.m. on the date shown on Your confirmation of coverage. However, if You are absent from work due to Injury, or Sickness, temporary Layoff or Leave of Absence on the date Your change in coverage would normally begin, changes in coverage that You make will begin on the date You return to Active Employment.

Changes in coverage will not affect a Payable Claim that occurs prior to the effective date of the change.

## **Employer Changes to the Policy**

Once Your coverage begins and You are in Active Employment or on a covered Layoff or Leave of Absence, any coverage changes made by Your Employer, consistent with the options you select, will take effect on the date agreed upon by Unum and Your Employer.

If You are not in Active Employment due to Injury or Sickness, any change in coverage requested by Your Employer will begin on the date You return to Active Employment.

Coverage changes will not affect a Payable Claim that occurs prior to the effective date of the change.

**Termination of Employee Coverage.** If You choose to cancel Your coverage under the policy, Your coverage ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Your coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You are no longer in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions; or
- last day You are in Active Employment. However, as long as premium is paid as required, coverage will continue if You elect to continue coverage under the Portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy.

Coverage on Your Dependent Children ends on the earliest of the date Your coverage under the policy ends or the date a dependent child no longer meets the definition of Dependent Children.

Unum will provide coverage for a Payable Claim which occurs while You are covered under this policy.

**Termination of Spouse Coverage.** If You choose to cancel Your Spouse's coverage under the policy, coverage for Your Spouse ends on the first of the month following the date You provide notification to Your Employer.

Otherwise, Spouse coverage under the policy ends on the earliest of the:

- date this policy is cancelled;
- date You are no longer in an eligible group;
- date Your eligible group is no longer covered;
- date of Your death;
- last day of the period for which You made any required contributions;
- last day You are in Active Employment. However, as long as premium is paid as required, coverage will continue if You elect to continue coverage under the Portability provision or in accordance with the Layoff and Leave of Absence provisions of this policy;
- date Your coverage under the policy ends;
- date Your Spouse no longer meets the definition of Spouse; or
- date of divorce or annulment.

Unum will provide coverage for a Payable Claim which occurs while Your Spouse is covered under the policy.

**Layoff.** If You are on a temporary Layoff, and if premium is paid, any Insured will be covered through the end of the month that immediately follows the month in which Your temporary Layoff begins.

**Leave of Absence.** If You are on a Leave of Absence, other than for family or medical leave, and if premium is paid, any Insured will be covered through the end of the month that immediately follows the month in which Your Leave of Absence begins.

**Absence Due to Injury or Sickness.** If You are not working due to Injury or Sickness, and if premium is paid, any Insured may continue to be covered subject to the Termination of Employee Coverage provision.

**Continuing Coverage while Employee is on Family and Medical Leave of Absence.**

Unum will continue coverage in accordance with Your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and Your Employer approved Your leave in writing.

Coverage will be continued until the end of the latest of the leave period:

- required by the Federal Family and Medical Leave Act of 1993 and any amendments;
- required by applicable state law; or
- provided to You for an Injury or Sickness.

If Your Employer's Human Resource policy does not provide for continuation of Your coverage during a family and medical leave of absence, Your coverage will be reinstated when You return to Active Employment.

Unum will not:

- apply a new Eligibility Waiting Period; or
- require Evidence of Insurability.

**Insurance Fraud.** Unum wants to ensure You and Your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

Any person who knowingly files a statement of claim containing any false or misleading information may be subject to criminal and civil penalties.

In addition, submission of false information in connection with the claim form may also constitute a crime under federal laws. Unum will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

**Contestability of Statements in Application or Evidence of Insurability.** Unum considers any statements You make in a signed application or Evidence of Insurability form, or that Your Employer makes in the application process, a representation and not a warranty. If any of the statements You or Your Employer make are not complete and/or not true at the time they are made, We can:

- reduce or deny any claim; or
- cancel Your coverage from the original effective date.

As a basis for doing this, We will use only statements made by the Employer in the application process or statements made by You in a signed application or Evidence of Insurability form.

Except in the case of fraud, Unum can take action only in the first two years any Insured's coverage is in force.

If the Employer gives Unum information about You that is incorrect, Unum will:

- use the facts to decide whether You have coverage under the policy and in what amounts; and
- make a fair adjustment of the premium.

**Employer as Agent.** For purposes of this policy, the Employer acts on its own behalf or as the Employee's agent. Under no circumstances will the Employer be deemed the agent of Unum.

**Communicating with You or Your Employer.** Unum may provide notices, information and other communications to You or Your Employer in written, electronic or telephonic form.

**Workers Compensation or State Disability Insurance.** This policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**Cancellation or Modification of this Policy.** This Policyholder Provision applies to Your coverage. This policy can be cancelled by:

- Unum; or
- the Policyholder.

Unum may cancel or modify this policy if:

- our participation requirements are not met, as applicable;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the Employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Us the names of any Employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its Employees;
- Unum provides 45 days notice at any time after the Initial Rate Guarantee for any reason; or
- Unum is notified of a change in Federal or State Law materially affecting the policy.

If Unum cancels or modifies this policy, for any of the reasons listed above, a written notice will be delivered to the Policyholder at least 45 days prior to the cancellation date or modification date. The Policyholder may cancel this policy if the modifications are unacceptable.

If any premium is not paid during the 31 day Grace Period, this policy will cancel automatically at the end of the Grace Period. The Policyholder is liable for premium for coverage during the Grace Period. The Policyholder must pay Us all premiums due for the full period this policy is in force. In the event of termination, this policy may be reinstated only as agreed upon by Unum and the Policyholder. If Unum agrees to reinstate this policy, such reinstatement will not constitute waiver of the termination provision in the future.

The Policyholder may cancel this policy by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy, coverage will end at 12:00 midnight on the last day of coverage.

If this policy is cancelled, the cancellation will not affect a Payable Claim.

## BENEFIT INFORMATION

### CRITICAL ILLNESS BENEFIT

Benefits for Cancer and Carcinoma in Situ, as defined in this Critical Illness Benefit, are based on diagnosis and not treatment. Cancer will be covered at 100% of the Face Amount and Carcinoma in Situ will be covered at 25% of the Face Amount, subject to the terms of coverage. The extent of treatment recommended, including but not limited to surgery, chemotherapy and/or radiation, will not affect the benefit amount.

#### Examples

A 50-year old has a \$50,000 Face Amount. At age 60, she discovers a lump in her breast. Benefits are calculated as follows:

If the lump is malignant and meets the definition of Cancer: \$50,000 Face Amount x 100% = \$50,000

If the lump is malignant and meets the definition of Carcinoma in Situ: \$50,000 Face Amount x 25% = \$12,500

If the lump is benign, it will not meet the definition of Cancer or Carcinoma in Situ and no coverage is provided.

#### Definitions

**Benign Brain Tumor** means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. The tumor must result in persistent neurological deficits including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption.

For the purposes of this policy, the following are not considered Benign Brain Tumors:

- tumors of the skull;
- pituitary adenomas; and
- meningiomas.

We will not pay for Benign Brain Tumors for individuals diagnosed with any of the following conditions prior to the Insured's coverage effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; or
- Turcot Syndrome.

**Blindness** means clinically proven irreversible reduction of sight in both eyes certified by an ophthalmologist with:

- sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
- visual field restriction to 20° or less in both eyes.

**Cancer** means a disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The following are not to be construed as Cancer for the purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Carcinoma in Situ;
- Basal cell carcinoma and squamous cell carcinoma of the skin, unless metastatic disease develops; or
- melanoma that is diagnosed as Clark's Level I or II or Breslow less than .75 mm or melanoma in situ.

**Carcinoma in Situ** means a malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). The following are not to be construed as Carcinoma in Situ for the purposes of this policy:

- pre-malignant conditions or conditions with malignant potential;
- Basal cell carcinoma and squamous cell carcinoma of the skin; or
- melanoma or melanoma in situ.

**Cerebral Palsy** means a group of disorders of the development of movement and posture causing activity limitation, that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and/or behavior and/or by a seizure disorder.

**Cleft Lip or Palate** means there is a definite clinical diagnosis of either cleft lip or cleft palate. A cleft lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A cleft palate is an opening between the roof of the mouth and the nasal cavity.

This policy covers clefts occurring on one side of the mouth (unilateral clefting) or on both sides of the mouth (bilateral clefting).

**Clinical Diagnosis** of Cancer or Carcinoma in Situ is based on the study of symptoms. We will pay benefits for a Clinical Diagnosis only if:

- there is medical evidence to support a positive diagnosis of Cancer or Carcinoma in Situ; and
- the diagnosis is made by a qualified Physician whose positive diagnosis of malignancy is consistent with professional medical standards of care for Cancer or Carcinoma in Situ.

**Coma as the Result of Severe Traumatic Brain Injury** means a coma resulting from a severe traumatic brain injury that results in a continuous state of profound



unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of:

- eye opening;
- verbal response; and
- motor response.

The condition must require intubation for respiratory assistance.

**Coronary Artery Bypass Surgery** means Heart Disease or Angina that has been clinically diagnosed and requires the Insured to undergo Coronary Artery Bypass Surgery, which is a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts. Coronary Artery Bypass Surgery does not include percutaneous coronary intervention (balloon angioplasty, stent implantation or related procedures to increase the flow of blood through the coronary arteries).

**Covered Accident** is an accident which:

- occurs on or after the coverage effective date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in the Certificate of Coverage.

**Critical Illness(es)** means Benign Brain Tumor, Blindness, Cancer and Carcinoma in Situ, Coma as the Result of Severe Traumatic Brain Injury, Coronary Artery Bypass Surgery, End Stage Renal (Kidney) Failure, Heart Attack (Myocardial Infarction), Major Organ Failure, Permanent Paralysis as the result of a Covered Accident, and Stroke as defined in this policy. For Dependent Children, Critical Illness also means Cerebral Palsy, Cleft Lip or Palate, Cystic Fibrosis, Down Syndrome and Spina Bifida.

**Cystic Fibrosis** means a definite diagnosis of Cystic Fibrosis by a licensed pediatrician or pulmonologist where the Dependent Child has chronic lung disease and pancreatic insufficiency. The diagnosis of Cystic Fibrosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L.

**Date of Diagnosis for Critical Illness** is:

- for Benign Brain Tumor, the date of diagnosis of the Benign Brain Tumor by examination of tissue (biopsy or surgical excision) or specific neuroradiological examination;
- for Blindness, the date the ophthalmologist makes an accurate certification of blindness as defined in the Blindness definition;
- for Cancer or Carcinoma in Situ, the date the tissue specimen, blood samples and/or titer(s) are taken on which the diagnosis of Cancer or Carcinoma in Situ is based;
- for Cerebral Palsy, defined as a group of disorders of the development of movement and posture causing activity limitation, that are attributed to progressive disturbances that occurred in the developing fetal or infant brain, the date of diagnosis of Cerebral Palsy is the date a licensed pediatrician or neurologist diagnoses Cerebral Palsy after live birth;
- for Cleft Lip or Palate, the date of diagnosis of Cleft Lip or Palate (unilateral or bilateral clefting) by Physician after live birth;

- for Coma as the Result of Severe Traumatic Brain Injury, the date a Physician confirms a Coma as the Result of Severe Traumatic Brain Injury lasting 14 or more consecutive days;
- for Coronary Artery Bypass Surgery, the date the Coronary Artery Bypass Surgery occurs;
- for Cystic Fibrosis, the date of diagnosis where Cystic Fibrosis has been definitively confirmed and established via a sweat test with sweat chloride concentrations greater than 60 mmol/L after live birth;
- for Down Syndrome, the date of diagnosis of Down Syndrome through the study of the 21st chromosome revealing Trisomy 21, Translocation or Mosaicism after live birth;
- for End Stage Renal (Kidney) Failure, the date the Insured's Physician recommends the Insured begin renal dialysis;
- for Heart Attack (Myocardial Infarction), the date that the ischemic death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack (Myocardial Infarction) definition;
- for Major Organ Failure, the date that the Insured is placed on the UNOS list for transplantation;
- for Permanent Paralysis as the result of a Covered Accident, the date a Covered Accident occurred which caused Permanent Paralysis continuing for a period of 90 consecutive days as confirmed by the attending Physician or immediately if the spinal cord is completely and irreparably transected;
- for Spina Bifida, the date of diagnosis of Meningocele or Myelomeningocele Spina Bifida by a Physician familiar with the diagnosis and/or treatment of Spina Bifida after live birth;
- for Stroke, the date a Stroke occurred based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater.

**Down Syndrome** means diagnosis of Down Syndrome through study of the 21st chromosome. Diagnosis must be confirmed by a licensed pediatrician or another Physician familiar with Down Syndrome diagnosis.

Down Syndrome includes:

- Trisomy 21 - An individual has three instead of two number 21 chromosomes.
- Translocation - An extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - The individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

**End Stage Renal (Kidney) Failure** means chronic irreversible failure of the function of both kidneys such that regular hemodialysis or peritoneal dialysis is required to sustain life.

**Heart Attack (Myocardial Infarction)** means there is an identifiable clinical event consistent with a heart attack:

- which is defined as having two of the following three:
  - typical chest pain;
  - electrocardiographic (EKG) changes indicative of Myocardial Infarction; in the case of Myocardial Infarction associated with percutaneous coronary intervention (balloon

angioplasty, stent implantation, and related procedures to increase the flow of blood through the coronary arteries), evolving ST elevations or new Q wave changes must be documented and included as one of the criteria on establishing a diagnosis; or

- elevation of biochemical markers of myocardial necrosis;

- and that results in some permanent functional loss of heart contraction detectable by a regional contraction abnormality study on an imaging study.

In the event of death, an autopsy confirmation and/or death certificate identifying Myocardial Infarction as the cause of death will be accepted.

**Major Organ Failure** means diagnosis of major organ failure of the liver, both lungs, pancreas, or heart resulting in the Insured being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung); a single benefit will be paid.

Only one Major Organ Failure benefit will be paid per Insured.

**Pathological Diagnosis** of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a qualified Physician whose positive diagnosis of malignancy is in keeping with the professional medical standards of care for Cancer or Carcinoma in Situ.

**Permanent Paralysis as the Result of a Covered Accident** means the complete and permanent loss of the use of two or more limbs through paralysis for a continuous period of 90 days as confirmed by a Physician.

In the case of a transected spinal cord with supporting clinical and radiological evidence and no expectation of return of function, the continuous 90 days requirement specified above is waived.

**Spina Bifida** means a confirmed diagnosis of either of the following types of Spina Bifida:

- Meningocele - The protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage. Individuals may suffer minor disabilities. New problems can develop later in life; or
- Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine. This is the most serious type of Spina Bifida, which causes nerve damage and more severe disabilities.

Diagnosis must be made by a licensed Physician familiar with Spina Bifida.

This policy excludes spina bifida occulta.

**Stroke** means a cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis must be supported by:

- evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

The following are not to be construed as a Stroke for purposes of this policy:

- transient ischemic attack;
- brain Injury related to trauma or infection;
- brain Injury associated with hypoxia, anoxia or hypotension;
- vascular disease affecting the eye or optic nerve; and
- ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

### **Benefit Payment Conditions for Critical Illness**

If, while the Insured's coverage is in force, the Insured is diagnosed with a Critical Illness by a Physician, Unum will pay a benefit subject to the benefit payment conditions listed below and the Critical Illness Benefit Reduction provision. Once a Critical Illness has been diagnosed and an Initial Diagnosis Benefit has become payable for that Critical Illness, an Initial Diagnosis Benefit for a separate and subsequently diagnosed Critical Illness will not be payable unless that subsequently diagnosed Critical Illness is medically unrelated to the previously diagnosed Critical Illness and separated by a period of 90 days. Only one Initial Diagnosis Benefit will ever be paid per Critical Illness per Insured.

Unum will pay benefits for the Critical Illnesses listed below if:

- the Date of Diagnosis is while the Insured's coverage is in force under the policy; and
- payment is not precluded by any general or specific exclusion or limitation set forth in this policy or any failure to meet any condition set out in the policy.

If any Dependent Children are insured as more than one Employee's Dependent Children, Unum will only pay benefits under one of the Employee's coverage. You may choose which Employee's coverage that benefits will be paid under by sending Unum written notice of Your choice.

### **Benign Brain Tumor**

**Initial Diagnosis Benefit.** If the Date of Diagnosis for a Benign Brain Tumor is after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Benign Brain Tumor shown in the Benefits at a Glance.

### **Blindness**

**Initial Diagnosis Benefit.** If the Date of Diagnosis for Blindness is after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Blindness shown in the Benefits at a Glance.

## **Cancer**

**Initial Diagnosis Benefit.** If the Date of Diagnosis for Cancer is after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Cancer shown in the Benefits at a Glance.

## **Carcinoma in Situ**

**Initial Diagnosis Benefit.** If the Date of Diagnosis for Carcinoma in Situ is after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Carcinoma in Situ shown in the Benefits at a Glance.

## **Cerebral Palsy**

**Initial Diagnosis Benefit.** If a Dependent Child has a Date of Diagnosis for Cerebral Palsy after the Dependent Child's coverage effective date, Unum will pay the Percentage of Coverage Amount for Cerebral Palsy shown in the Benefits at a Glance.

## **Cleft Lip or Palate**

**Initial Diagnosis Benefit.** If a Dependent Child has a Date of Diagnosis for Cleft Lip or Palate after the Dependent Child's coverage effective date, Unum will pay the Percentage of Coverage Amount for Cleft Lip or Palate shown in the Benefits at a Glance.

## **Coma as the Result of Severe Traumatic Brain Injury**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Coma as the Result of Severe Traumatic Brain Injury after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Coma as the Result of Severe Traumatic Brain Injury shown in the Benefits at a Glance.

## **Coronary Artery Bypass Surgery**

**Initial Diagnosis Benefit.** If the Date of Diagnosis for Coronary Artery Bypass Surgery is after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Coronary Artery Bypass Surgery shown in the Benefits at a Glance.

## **Cystic Fibrosis**

**Initial Diagnosis Benefit.** If a Dependent Child has a Date of Diagnosis for Cystic Fibrosis after the Dependent Child's coverage effective date, Unum will pay the Percentage of Coverage Amount for Cystic Fibrosis as shown in the Benefits at a Glance.

## **Down Syndrome**

**Initial Diagnosis Benefit.** If a Dependent Child has a Date of Diagnosis for Down Syndrome after the Dependent Child's coverage effective date, Unum will pay the Percentage of Coverage Amount for Down Syndrome shown in the Benefits at a Glance.

## **End Stage Renal (Kidney) Failure**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for End Stage Renal (Kidney) Failure after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for End Stage Renal (Kidney) Failure shown in the Benefits at a Glance.

## **Heart Attack (Myocardial Infarction)**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Heart Attack (Myocardial Infarction) after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Heart Attack (Myocardial Infarction) shown in the Benefits at a Glance.

## **Major Organ Failure**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Major Organ Failure after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Major Organ Failure shown in the Benefits at a Glance.

## **Permanent Paralysis as the result of a Covered Accident**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Permanent Paralysis as the result of a Covered Accident after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Permanent Paralysis as the result of a Covered Accident shown in the Benefits at a Glance.

## **Spina Bifida**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Spina Bifida after the Dependent Child's coverage effective date, Unum will pay the Percentage of Coverage Amount for Spina Bifida shown in the Benefits at a Glance.

## **Stroke**

**Initial Diagnosis Benefit.** If an Insured has a Date of Diagnosis for Stroke after the Insured's coverage effective date, Unum will pay the Percentage of Coverage Amount for Stroke shown in the Benefits at a Glance.

## **Critical Illness Benefit Reduction**

Any coverage in force prior to the Insured's 70th birthday will be reduced on the Policy Anniversary Date following the Insured's 70th birthday. The Insured's Coverage Amount will be reduced to 50% of the Coverage Amount the Insured had prior to the Policy Anniversary Date. Any coverage in force after the Policy Anniversary Date following the Insured's 70th birthday will not be subject to a benefit reduction on subsequent Policy Anniversary Dates. There will be no further increases in the Insured's Coverage Amount.

## **WELLNESS BENEFIT**

Unum will pay the Wellness Benefit Amount shown in the Benefits at a Glance for one Wellness Test per Calendar Year per Insured if the Insured has a Wellness Test performed while the Insured's coverage is in force.

Wellness tests are:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);
- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Hemoglobin A1C(HbA1c);
- Flexible sigmoidoscopy;
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Virtual colonoscopy.

### **LIMITATIONS AND EXCLUSIONS**

Unum will not pay benefits for a claim that is caused by, contributed to by or occurs as a result of:

- participating or attempting to participate in a felony or being engaged in an illegal occupation;
- committing or trying to commit suicide or injuring oneself intentionally, whether sane or not;
- participating in war or any act of war, whether declared or undeclared; or
- being under the influence of or addicted to intoxicants or narcotics. This would not include Physician prescribed medication, taken in the prescribed dosage.

## OTHER FEATURES

### Your Right to Continue Coverage (Portability)

If, while You are covered under the policy, Your employment with the Policyholder ends, You are no longer in an eligible group or the policy is being terminated by the Policyholder and is not being replaced, You may have the right to apply to continue coverage under the policy for Yourself, Your Spouse, if covered, and Your Dependent Children. You must apply for coverage under this portability provision and pay the first premium within 31 days after the date Your employment ends, You are no longer in an eligible group or the date the policy is terminated by the Policyholder and is not being replaced.

You are not eligible to apply for continuing coverage under this provision if the policy is closed to new enrollments or Your coverage under the policy ends for any of the following reasons:

- the policy is cancelled by Unum; or
- the policy is being terminated by the Policyholder and is being replaced.

Except as provided in this section, Your continuing coverage will be the same coverage provided You under the policy as of the date Your employment ends, the policy is terminated by the Policyholder and is not replaced, or You are no longer in an eligible group. Any subsequent change to the policy will not apply to Your continuing coverage.

Your continuing coverage is subject to all of the provisions, exclusions and limitations of the policy, except that:

- premiums will be billed directly to You;
- initial premium rates will be based on the portability rates in effect at the time You apply to continue Your coverage; and
- premium rates can be changed by Unum at any time upon 45 days notice to You so long as the change is not due to any change in your age or health or the age or health of Your Spouse or Your Dependent Children.

Your continuing coverage, and any coverage of Your Spouse and Dependent Children, will end on the earliest to occur of:

- Your failure to pay the required premium within the 31 day Grace Period;
- unless Your Spouse applies for continuing coverage under the following provision, the date You die; or
- the coverage under this portability provision is cancelled by Unum for any reason upon 45 days notice.

Once continuing coverage is cancelled it can not be reinstated.

In the event the Policyholder's coverage under the policy is cancelled or closed to new enrollments, the policy will remain in effect for the benefit of those who have continued their coverage under this provision prior to the policy cancellation date or that date.



## **The Right of Your Spouse to Continue Coverage if You Die, or are Divorced (Spouse Portability)**

If You die or divorce, Your Spouse may have the right to apply to continue coverage under the policy.

Your Spouse must apply for coverage under this portability provision and pay the first premium within 31 days after the date of Your death or divorce.

Your Spouse is not eligible to apply to continue coverage under this provision if Your Spouse was not insured under this policy on the date of Your death or divorce.

Except as provided in this section, your Spouse's continuing coverage will be the same coverage provided Your Spouse under the policy as of the date of Your death or divorce and any subsequent change to the policy will not apply to Your Spouse's continuing coverage.

If You die and Your Spouse applies to continue coverage, any eligible Dependent Children will be covered under Your Spouse's continued coverage. Critical Illness Coverage for Dependent Children will be provided at 25% of Your Spouse's Critical Illness Coverage Amount.

Your Spouse's continuing coverage is subject to all of the provisions, exclusions and limitations of the policy, except that:

- premiums will be billed directly to Your Spouse;
- initial premium rates will be based on the portability rates in effect at the time Your Spouse applies to continue coverage; and
- premium rates can be changed by Unum at any time upon 45 days notice to Your Spouse.

Your Spouse's and any Dependent Children's continuing coverage will end on the earliest to occur of:

- Your Spouse's failure to pay the required premium within the 31 day Grace Period;
- the date Your Spouse dies; or
- the coverage under this portability provision is cancelled by Unum for any reason upon 45 days notice.

Once continuing coverage is cancelled it cannot be reinstated.

In the event the Policyholder's coverage under the policy is cancelled or closed to new enrollments, the policy will remain in effect for the benefit of those who have continued their coverage under this provision prior to the policy cancellation date or that date.

## STATE REQUIREMENTS

### CALIFORNIA CONTACT NOTICE

**GENERAL QUESTIONS:** If you have any general questions about your insurance, you may contact the Insurance Company by:

**CALLING:**

1-800-421-0344 (Customer Information Call Center)

**-OR-**

**WRITING TO:**

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

**COMPLAINTS:** If a complaint arises about your insurance, you may contact the Insurance Company by:

**CALLING:**

(Compliance Center Complaint Line)  
Toll free: 1-800-321-3889, Option 2  
Direct: 207-575-7568

**-OR-**

**WRITING TO:**

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

**WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE PROVIDE YOUR INSURANCE POLICY NUMBER.**

If the Policy or Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street - South Tower  
Los Angeles, California 90013  
In-State Toll Free Hotline Telephone Number: 1-800-927-4357  
Local Telephone Number: 213-897-8921  
Office Hours: 8:00 a.m. - 5:00 p.m.

This form is for contact information only, and it is not to be considered a condition for the Policy.

## GENERAL DEFINITIONS

Additional definitions may be contained in other policy provisions, amendments or riders.

**Active Employment** means You are working for Your Employer for earnings that are paid regularly and that You are performing the material and substantial duties of Your regular occupation. You must be regularly scheduled to work on average at least the minimum number of hours as described under Minimum Hours Requirement shown in the Benefits at a Glance.

Your work site must be:

- Your Employer's usual place of business;
- an alternative work site at the direction of Your Employer; or
- a location to which Your job requires You to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**Calendar Year** means the period beginning on the Insured's coverage effective date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

**Certificate of Coverage** means a written statement prepared by Unum and may include attachments. It tells You:

- the coverage to which the Insured may be entitled;
- to whom benefits are payable; and
- limitations, exclusions and/or requirements that apply within this policy.

**Covered Loss** means a condition covered by this policy as shown in the Benefits at a Glance and as applied for by You and approved by Unum.

**Dependent Child(ren)** means Your unmarried children from live birth but less than age 25. Dependent Children include Your own natural offspring, lawfully adopted children and stepchildren, including children of Your domestic partner. They also include foster children and other children who are dependent on You for main support and living with You in a regular parent-child relationship. A child will be considered adopted on the date of placement in Your home.

After attainment of age 25 Dependent Child(ren) also includes dependent children who became incapable of self-sustaining employment, prior to age 25, due to mental or physical handicap. Such child will continue to be an Insured subject to the following: (1) the Employee must furnish proof of such incapacity and dependency to Unum within 31 days of the child's 25th birthday; and (2) proof of continued incapacity and dependency must be furnished at Our request, but not more than annually, after the two year period following the child's 25th birthday.

No Dependent Child can be covered as both an Employee and a Dependent Child.

**Eligibility Waiting Period** means the continuous period of time that You must be in Active Employment in an eligible group before You are eligible for coverage as determined by Unum and Your Employer.

**Employee** means a person who is in Active Employment in the United States with the Employer.

**Employer** means the Policyholder and includes any division, subsidiary or affiliated company.

**Enrollment** means a period of time determined by Unum and Your Employer during which You are eligible to enroll for or change Your coverage. This period of time may be limited.

**Evidence of Insurability** means a statement of Your or Your Spouse's medical history which Unum will use to determine if You or Your Spouse are approved for coverage. Evidence of Insurability will be at Unum's expense.

**Grace Period** means the period of time following the premium due date during which premium payment may be made.

**Injury** means a bodily injury which is the result of an accident.

**Insured** means any person covered under the policy.

**Layoff or Leave of Absence** means that You are temporarily absent from Active Employment for a period of time that has been agreed to in advance in writing by Your Employer.

Your normal vacation time is not considered a temporary Layoff or Leave of Absence.

**Payable Claim** means a claim for which Unum is liable under the terms of the policy.

**Physician** means a person performing tasks that are within the limits of his or her medical license and is:

- licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize You, Your Spouse, Dependent Children, parents or siblings, a business or professional partner, or any person who has a financial affiliation or business interest with You, as a Physician for a claim that You send to Us.

**Policyholder** means the Employer to whom the policy is issued.

**Sickness** means an illness or disease.

**Spouse** means Your lawful Spouse, including a legally separated Spouse, residing in the United States. You may not cover Your Spouse if Your Spouse is enrolled for coverage as an Employee. Spouse, wherever used, includes domestic partner. Domestic Partnership is established in California when both persons file a Declaration

of Domestic Partnership with the Secretary of State, pursuant to Family Code Section 297 through 297.5, and, at the time of filing, all of the following requirements are met:

- both persons have a common residence;
- neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
- the two persons are not related by blood in a way that would prevent them from being married to each other in California;
- both persons are at least 18 years of age;
- both persons are capable of consenting to the Domestic Partnership; and
- either of the following:
  - both persons are members of the same sex; or
  - one or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 492(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a Domestic Partnership unless one or both of the persons are over the age of 62.

**We, Us** and **Our** means Unum Life Insurance Company of America.

**You, Your** and **Yourself** means an Employee who is eligible for Unum coverage.

## **Additional Claim and Appeal Information**

### **APPLICABILITY OF ERISA**

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following provisions are part of the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

This coverage may be provided under a Plan that provides other benefits as well. Contributions to the Plan are made as stated under your certificate of coverage. The contributions made by you and your Employer, if any, for this coverage may be used by the Plan to provide any of the benefits under the Plan. The Employer is ultimately responsible for paying any difference between the total cost of benefits under the Plan and the amounts you and other employees contribute.

### **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. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), and your attending physician. If you or your authorized representative should have any questions about what to do, you or your authorized representative may contact Unum directly.

### **CLAIMS PROCEDURES**

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

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

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

## APPEAL PROCEDURES

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:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

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

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Plan 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 a 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.

**NOTICE OF PROTECTION PROVIDED BY  
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association (“the Association”). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that the member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers’ care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations or the rights or obligations of the Association.

**COVERAGE**

**Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

**Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  - 80% of death benefits but not to exceed \$300,000
  - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- Annuities and Structured Settlement Annuities
  - 80% of present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of April 1, 2011, is \$470,125. This amount will increase or decrease based



upon changes in the health care cost component of the consumer price index to the date on which the insurer became an insolvent insurer.

### **COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE**

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans to the extent they are self funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

### **NOTICES**

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at [www.califega.org](http://www.califega.org), or contact either of the following:

California Life and Health Insurance  
Guarantee Association  
P.O. Box 16860  
Beverly Hills, CA 90209-3319  
(323) 782-0182

California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street  
Los Angeles, CA 90013  
(800) 927-4357

**Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.**