



Hutto Independent School District

Your Group Short Term Disability Plan

Policy No. 474704 011

Underwritten by Unum Life Insurance Company of America

9/15/2020

CERTIFICATE OF COVERAGE

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's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

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, Maine 04122

The insurance policy under which this certificate is issued is not a policy of Workers' Compensation Insurance. You should consult your Employer to determine whether your employer is a subscriber to the Workers' Compensation system.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right of appeal.

Unum

To file a complaint through your insurance company or HMO:

Call: Customer Relations
Toll-Free: 800-321-3889; Option 2
Email: custrel@unum.com
Mail: 2211 Congress Street
Portland, Maine 04122

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar un queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Unum

Para presentar una queja a través de su compañía de seguros o HMO:

Llamada: Relaciones con el cliente
Teléfono gratuita: 800-321-3889; Opción 2
Correo electrónico: custrel@unum.com
Dirección postal: 2211 Congress Street
Portland, Maine 04122

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714-9091

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BENEFITS AT A GLANCE

SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: September 1, 2020

POLICY NUMBER: 474704 011

ELIGIBLE GROUP(S):

All Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be in active employment at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before the plan effective date: None

For employees entering an eligible group after the plan effective date: First of the month coincident with or next following the date you enter an eligible group

Employees are not eligible for coverage until the waiting period has been completed.

ENROLLMENT:

Employees who are eligible may apply for and change their coverage at any time within the first 60 days of being eligible.

After 60 days, employees who are eligible may apply for and change their coverage during any scheduled enrollment period or within 60 days of a change in status.

You may decrease or cancel any coverage for which you make contributions at any time.

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

You must make contributions for your coverage.

Premium contributions are required for your coverage while you are receiving benefit payments under this plan.

ELIMINATION PERIOD:

Option 1

0 days for disability due to an injury

7 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 2

0 days for disability due to an injury

7 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 3

0 days for disability due to an injury

7 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 4

14 days for disability due to an injury

14 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 5

14 days for disability due to an injury

14 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 6

14 days for disability due to an injury

14 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 7

30 days for disability due to an injury

30 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 8

30 days for disability due to an injury

30 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Option 9

30 days for disability due to an injury

30 days for disability due to a sickness

If, because of your disability, you are hospital confined as an inpatient, benefits begin on the first day of inpatient confinement.

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

Option 1

45% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 2

55% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 3

65% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 4

45% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 5

55% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 6

65% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 7

45% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 8

55% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Option 9

65% of weekly earnings to a maximum benefit of \$2,500 per week

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered under this plan.

Your Short Term Disability plan does not cover disabilities due to an occupational sickness or injury.

MINIMUM WEEKLY BENEFIT:

\$25

MAXIMUM PERIOD OF PAYMENT:

Option 1

13 weeks

Option 2

13 weeks

Option 3

13 weeks

Option 4

11 weeks

Option 5

11 weeks

Option 6

11 weeks

Option 7

9 weeks

Option 8

9 weeks

Option 9

9 weeks

OTHER FEATURES:

Continuity of Coverage

Pre-Existing: 3/12

Rehabilitation and Return to Work Assistance Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage and if you make contributions to the plan, 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

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible so that a claim decision can be made in a timely manner. Notice of claim should be sent within 30 days after the date your disability begins. In addition, you must send Unum proof of your claim no later than one year after the date your disability begins unless your failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in this policy, even if your failure to provide proof of claim is due to a lack of legal capacity or if state law provides an exception to the one year time period.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE PROOF OF CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

The form to use to submit your proof of claim is available from your Employer, or you can request the form from us. If you do not receive the form from Unum or your Employer within 15 days of your request, send Unum proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the **regular care** of a **physician**;
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians; and
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. We may also require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request by us. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to meet with and be interviewed by an authorized Unum Representative. Unum will deny your claim, or stop sending you payments, if you fail to comply with our requests.

The initial payment for a payable claim will be made within 60 days from the date proof is received.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

Unum will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under this policy may be recovered by us by offsetting against amounts otherwise payable to you under this policy, or by other legally permitted means.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your **waiting period**.

WHAT COVERAGE OPTIONS DOES THE PLAN PROVIDE?

If the plan provides additional coverage options for you to select from, you may apply for these other options. Refer to the **BENEFITS AT A GLANCE** section and the **BENEFIT INFORMATION** section for the additional coverage options, if any.

WHEN DOES YOUR COVERAGE BEGIN?

Your coverage will begin at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for coverage, if you apply within 60 days after your eligibility date.

WHEN CAN YOU APPLY FOR COVERAGE IF YOU DID NOT APPLY OR DECLINED WHEN YOU WERE FIRST ELIGIBLE FOR COVERAGE OR YOU VOLUNTARILY CANCELLED YOUR COVERAGE?

You can apply for coverage only during a **scheduled enrollment period** or within 60 days of a **change in status**. The pre-existing condition will apply.

Unum and your Employer determine when the scheduled enrollment period begins and ends. Coverage applied for during the scheduled enrollment period will begin at 12:01 a.m. on the date you apply for coverage.

Coverage applied for due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 60 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

HOW CAN YOU CHANGE YOUR COVERAGE?

You can change your coverage options, if any, at the time specified in the **BENEFITS AT A GLANCE** section.

You may choose to:

- increase your coverage up to the maximum weekly benefit available under the plan;
- decrease your coverage provided it is not less than an amount available on the plan; or
- choose not to participate in the plan.

WHEN DO CHANGES IN YOUR COVERAGE TAKE EFFECT?

A change in coverage that is made during a scheduled enrollment period will begin at 12:01 a.m. on the first day of the month after the scheduled enrollment period.

Once your coverage begins, any decrease in coverage you make at other than a scheduled enrollment will take effect on the date the change is reported to us by your Employer or, if later the date specified by your Employer.

Any decrease in coverage will not affect a payable claim that occurs prior to the decrease.

If you are not in active employment due to injury or sickness, or if you are on a covered layoff or leave of absence any increased or additional coverage will begin on the date you return to active employment.

A change in coverage due to a **change in status** will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 60 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to **active employment**.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the school year in which your temporary layoff begins. However, if you are a contracted employee, and if premium is paid you will be covered through the end of your Employer's current school contract year in which your temporary layoff begins.

If you are on any other **leave of absence**, other than a family medical leave, and if premium is paid, you will be covered through the end of the school year in which your leave of absence begins. However, if you are a contracted employee, and if premium is paid, you will be covered through the end of your Employer's current school contract year in which your leave of absence begins.

WHAT HAPPENS TO YOUR COVERAGE UNDER THIS POLICY WHILE YOU ARE ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

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

Your coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If your Employer's Human Resource policy doesn't 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.

We will not:

- apply a new waiting period; or
- apply a new pre-existing condition exclusion.

WHEN WILL CHANGES MADE BY YOUR EMPLOYER TAKE EFFECT?

Once your coverage begins, any change requested by your Employer will take effect immediately if you are in active employment.

If you are not in active employment due to injury or sickness, or if you are on a covered layoff or leave of absence, any change requested by your Employer will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a **payable claim** that occurs prior to the effective date of the change.

WHEN DOES YOUR COVERAGE END?

If you choose to cancel your coverage under the policy or a plan, your coverage ends on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under the policy or a plan ends on the earliest of the following:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue:

- while benefits are being paid;
- while you are fulfilling the requirements of your elimination period; or
- in accordance with the layoff and leave of absence provisions of this policy or plan.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the later of when original proof of your claim was first required to have been given; or your claim was denied; or your benefits were terminated, unless otherwise provided under federal law.

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

Unum considers any statements you make in a signed application for coverage or that your Employer makes in the application process, a representation and not a warranty. If any of the material 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. A copy of the statements will be provided to you or your beneficiary. These statements cannot be used to reduce or deny coverage if your coverage has been in force for at least two years.

However, if the Employer gives us information about you that is incorrect, we will:

- use the facts to determine if you have coverage under the plan according to the policy provisions and in what amounts; and
- make a fair adjustment of the premium.

HOW MAY UNUM COMMUNICATE WITH YOU OR YOUR EMPLOYER?

Unum may provide notices, information and other communications to you or your Employer in written, electronic or telephonic form.

HOW WILL UNUM HANDLE 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.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete

or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

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

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that due to your **sickness** or **injury**:

- you are unable to perform the **material and substantial duties** of your **regular occupation**; and
- you are not working in any occupation.

We will continue to pay you a disability benefit after you have received benefits under this plan for at least 4 consecutive weeks if:

- you begin performing at least one of the material and substantial duties of your regular occupation or another occupation; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

If you have a Cesarean section, you will be considered disabled for a minimum period of 8 weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the 8 weeks.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

OPTION 1

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, benefits begin immediately.

If your disability is the result of a sickness, your elimination period is 7 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 2

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, benefits begin immediately.

If your disability is the result of a sickness, your elimination period is 7 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 3

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, benefits begin immediately.

If your disability is the result of a sickness, your elimination period is 7 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 4

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 5

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 6

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 14 days.

If your disability is the result of a sickness, your elimination period is 14 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 7

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 30 days.

If your disability is the result of a sickness, your elimination period is 30 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 8

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 30 days.

If your disability is the result of a sickness, your elimination period is 30 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

OPTION 9

You must be continuously disabled through your **elimination period**.

If your disability is the result of an injury that occurs while you are covered under the plan, your elimination period is 30 days.

If your disability is the result of a sickness, your elimination period is 30 days.

If, because of your disability, you are hospital confined as an **inpatient**, benefits begin on the first day of inpatient confinement.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment weekly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

OPTION 1

1. Multiply your weekly earnings by 45%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 2

1. Multiply your weekly earnings by 55%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 3

1. Multiply your weekly earnings by 65%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 4

1. Multiply your weekly earnings by 45%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 5

1. Multiply your weekly earnings by 55%.
2. The maximum **weekly benefit** is \$2,500.

3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 6

1. Multiply your weekly earnings by 65%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 7

1. Multiply your weekly earnings by 45%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 8

1. Multiply your weekly earnings by 55%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

OPTION 9

1. Multiply your weekly earnings by 65%.
2. The maximum **weekly benefit** is \$2,500.
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

WHAT ARE YOUR WEEKLY EARNINGS?

For enrollment purposes only, "Weekly Earnings" means your weekly income, as defined below, in effect on the date you are enrolling for coverage for the first time or any subsequent annual enrollment period. During enrollment, your weekly earnings are only used to determine the highest weekly benefit for which you are eligible.

"Weekly Earnings" means your current salary in effect just prior to your date of disability. It is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It includes stipends paid by your Employer or contracted in writing to be paid by your Employer, for the contract year during which you become disabled. It will only include stipends paid for participating as a coach or a leader in any school extracurricular activity for which you are paid.

It does not include income received from car, housing, or moving allowances, commissions, bonuses, overtime pay, shift differential, Employer contributions to a qualified deferred compensation plan or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly earnings from your Employer in effect just prior to the date your absence begins.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly **disability earnings**, if any, are less than 20% of your weekly earnings.

If you are continuously partially disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings, we will pay you the lesser of:

1. 50% of your weekly payment; or

2. your weekly earnings less earnings while partially disabled and less any of the deductible sources of income.

This is the amount Unum will pay you for each week.

Unum may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income.

HOW DO WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings have fluctuated from week to week, Unum may determine your benefit eligibility based on the average of your disability earnings over the most recent 3 weeks.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability retirement payments under any:
 - state compulsory benefit **act** or **law**.
 - group plan sponsored by your Employer.
 - other group insurance plan.
 - **governmental retirement system**.
2. The amount that you receive:
 - under the mandatory portion of any "no fault" motor vehicle **plan**.
 - under Title 46, United States Code Section 688 (The Jones Act).
 - from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 62 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post tax basis to the system.

Regardless of how retirement payments are distributed, Unum will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

- receive as disability payments under your Employer's **retirement plan**.
- voluntarily elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your **Employer's contribution** to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

5. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:

- the United States Social Security Act.
- the Canada Pension **Plan**.
- the Quebec Pension Plan.
- any similar plan or act.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable for the same period of disability for which we are paying benefits.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)

- individual disability income plans
- **salary continuation** or **accumulated sick leave** plans, except disability income payments you receive under a group plan sponsored by your Employer

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: \$25.

Unum may apply this amount toward an outstanding overpayment.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1 and 5 in the deductible sources of income section, we will estimate your entitlement to these benefits and your Short Term Disability payment will be reduced by these estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1 and 5 in the deductible sources of income section, and if denied, appeal to all administrative levels Unum feels are necessary;
- provide documentation of your application and/or appeal; and
- sign Unum's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

OPTION 1

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 13 weeks during a continuous period of disability.

OPTION 2

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 13 weeks during a continuous period of disability.

OPTION 3

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 13 weeks during a continuous period of disability.

OPTION 4

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 11 weeks during a continuous period of disability.

OPTION 5

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 11 weeks during a continuous period of disability.

OPTION 6

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 11 weeks during a continuous period of disability.

OPTION 7

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 9 weeks during a continuous period of disability.

OPTION 8

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 9 weeks during a continuous period of disability.

OPTION 9

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 9 weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- after 4 consecutive weeks of payments, when you are able to return to work in your regular occupation on a **part-time basis** and you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury**, however, Unum will cover disabilities due to occupational sicknesses or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

WHAT IS A PRE-EXISTING CONDITION?

You have a pre-existing condition if you deny initial coverage and apply later at a scheduled enrollment period or change in status if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

In addition, this plan will not cover an increase in coverage made at a scheduled enrollment period or within 60 days of a change in status if you have a pre-existing condition. An increase in coverage includes, if applicable to the plan, applying for

additional benefit amounts and/or selecting a shorter elimination period. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to the date your coverage increased; and
- the disability begins in the first 12 months after your coverage increased.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which Unum made a payment:

Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for 14 consecutive days or less.

If you return to work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which Unum made a payment:

Unum will treat your current disability as part of your prior claim and you will not have to complete another elimination period when you are performing any occupation for your Employer on a full time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the policy provisions.

If you are covered under another group short term disability plan on the date of your recurrent disability and are entitled to payments under that plan, you will not be eligible for further payments from Unum.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION AFTER YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM OR AFTER YOU BECOME INSURED UNDER THE UNUM PLAN DUE TO A MERGER, ACQUISITION OR AFFILIATION? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

- a. the weekly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
- b. the weekly payment under the Unum plan.

Your elimination period will be the longer of:

- a. the elimination period under the prior plan if it had remained in force; or
- b. the elimination period under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.

HOW CAN UNUM'S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.

Your claim file will be reviewed by one of Unum's rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of \$250 per week.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income.

In addition, we will make weekly payments to you for 3 weeks following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum's Rehabilitation and Return to Work Assistance program; or
- any other date on which weekly payments would stop in accordance with this plan.

GLOSSARY

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 the minimum hours requirement in each plan.

Your work site must be:

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

Normal vacation is considered active employment.
Temporary and seasonal workers are excluded from coverage.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your **maximum capacity**.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

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 named in the policy.

EMPLOYER'S CONTRIBUTION in the context of a retirement plan that is part of any federal, state, county, municipal or association retirement system means any contribution made by your Employer and any contribution made on your behalf which has been picked up by your Employer under Internal Revenue Code Section 414(h)(2) so that it does not constitute taxable income to you.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal, state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the direct result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INPATIENT means that you are confined to a hospital room due to your sickness or injury for 23 or more consecutive hours. Your admission and discharge dates and time must be 23 or more consecutive hours apart.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time Unum will make payments to you for any one period of disability.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

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
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or

- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, 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.

PLAN means a line of coverage under the policy.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

SCHEDULED ENROLLMENT PERIOD means a period of time determined by Unum and your Employer.

SICKNESS means an illness or disease. Disability must begin while you are covered under the plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.

WE, US and **OUR** means Unum Life Insurance Company of America.

WEEKLY BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means an employee who is eligible for Unum coverage.

LONG TERM DISABILITY/SHORT TERM DISABILITY

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your employer or plan administrator for the most current state provisions that may apply to you.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of those states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

For residents of Colorado:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?** provision in the **BENEFIT INFORMATION** section of the policy and in the **SPOUSE DISABILITY BENEFIT** provision in the **OTHER BENEFIT FEATURES** section of the policy is amended to provide that any exclusion for disabilities caused by, contributed to by, or resulting from your intentionally self-inflicted injuries will be applied only if you were sane when the injury was inflicted.

For residents of Louisiana:

The **HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 3 years.

For residents of Minnesota:

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The ***WHAT ARE DEDUCTIBLE SOURCES OF INCOME?*** provision in the **BENEFIT INFORMATION** section of the policy is amended so that deductible sources of income will not include any amounts you receive as mandatory portions of any "no fault" motor vehicle plan or any amounts received from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise, until after you have been fully compensated from this other source.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

If your coverage includes the **Spouse Disability Rider** benefit the exclusions for mental illness and alcoholism applicable to the rider are removed.

For residents of Montana:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The definition of pre-existing condition found in the provisions ***WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?*** and ***WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?*** in the **BENEFIT INFORMATION** section of the policy, is amended to limit a pre-existing condition to "a sickness or injury for which you received medical advice or treatment from a provider of health care services or medical advice or treatment was recommended by a provider of health care services" during the time period specified in the policy.

For residents of New Hampshire:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The ***HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of North Carolina:

The definition of pre-existing condition found in the provisions **WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?** and **WHAT DISABILITIES ARE NOT COVERED FOR A COST OF LIVING INCREASE?** in the **BENEFIT INFORMATION** section of the policy, is amended by removing any reference to "symptoms arising from the sickness or injury, whether diagnosed or not."

For residents of South Carolina:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM?** provision in the **BENEFIT INFORMATION** section of the policy, is amended to provide that Unum will credit the pre-existing condition period you satisfied under another similar group disability policy if you were covered under the prior policy within 30 days of being effective under this policy and you applied for this coverage when you first became eligible.

For residents of South Dakota:

The **Pre-existing Condition** limitation in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** limitation in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Texas:

The **HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

The **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy will be applied by deleting the phrase "or you had symptoms for which an ordinarily prudent person would have consulted a health care provider."

For residents of Utah:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it

will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

The **HOW CAN STATEMENTS IN YOUR APPLICATION FOR THIS COVERAGE BE USED?** provision in the **GENERAL PROVISIONS** section of the policy is amended to provide that, except for fraud, misstatements made in your application cannot be used to reduce or deny coverage if your coverage has been in force for at least 2 years.

For residents of Vermont:

If the policy is marketed in Vermont, the policyholder has a principal office or is organized in Vermont, or there are more than 25 Vermont residents insured under the policy:

The limitation specifying the number of months payments will be made for a disability caused by a mental and nervous condition is removed.

The **MINIMUM HOURS REQUIREMENT** stated in the **BENEFITS AT A GLANCE** section of the policy is reduced to 17.5 hours per week.

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of West Virginia:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

For residents of Wisconsin:

The **Pre-existing Condition** exclusion in the **OTHER FEATURES** provision of the **BENEFITS AT A GLANCE** section of the policy is amended so that if the last number is greater than 12 months, it is reduced to 12 months and any **Pre-existing Condition** exclusion in the **BENEFIT INFORMATION** section of the policy is amended so that it will be applied only if the disability begins in the first 12 months after the insured's effective date of coverage for the applicable benefit, or such shorter time as provided in the policy.

Additional Claim and Appeal Information
Relative to policy issued by Unum Life Insurance Company of America ("Unum")

APPLICABILITY OF ERISA

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

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

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

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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.

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

OTHER RIGHTS

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

**Addendum to the "Additional Summary Plan Description Information"
included with your certificate of coverage or policy
and effective for claims filed on or after April 1, 2018.**

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).

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

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

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

Eligibility for Protection by the Association

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

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

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

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