

AMENDMENT NO. 6

This amendment forms a part of Group Identification No. 473781 001 issued to the Employer:

Caron Treatment Center

The entire Summary of Benefits is replaced by the Summary of Benefits attached to this amendment.

The effective date of these changes is July 1, 2022. The changes only apply to disabilities which start on or after the effective date.

The Summary of Benefits' terms and provisions will apply other than as stated in this amendment.

Dated at Portland, Maine on July 6, 2022.

Unum Life Insurance Company of America

By



Secretary

If this amendment is unacceptable, please sign below and return this amendment to Unum Life Insurance Company of America at Portland, Maine within 90 days of July 6, 2022.

YOUR FAILURE TO SIGN AND RETURN THIS AMENDMENT BY THAT DATE WILL CONSTITUTE ACCEPTANCE OF THIS AMENDMENT.

Caron Treatment Center

By _____
Signature and Title of Officer



**GROUP INSURANCE
SUMMARY OF BENEFITS
NON-PARTICIPATING**

IDENTIFICATION NUMBER: 473781 001

EFFECTIVE DATE OF COVERAGE: February 1, 2019

ANNIVERSARY DATE: July 1

GOVERNING JURISDICTION: Pennsylvania

**Unum Life Insurance Company of America
insures the lives of participating Employer members of the**

**Sagewell Healthcare Benefits Trust
(referred to as the Policyholder)**

Summary of Benefits for

**Caron Treatment Center
(referred to as the Employer)**

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this Summary of Benefits. Unum makes this promise subject to all provisions of this Summary of Benefits.

The Employer should read this Summary of Benefits carefully and contact Unum promptly with any questions. This Summary of Benefits 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.

Signed for Unum at Portland, Maine on the Effective Date of Coverage.



President



Secretary

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

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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. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

POLICYHOLDER'S ORIGINAL PLAN

EFFECTIVE DATE: February 1, 2019

EMPLOYER'S PLAN

EFFECTIVE DATE: February 1, 2019

IDENTIFICATION NUMBER: 473781 001

ELIGIBLE GROUP(S):

Group 1

All full-time exempt employees, non-exempt Registered Nurses & Salaried Student Assistance Program Employees in active employment in the United States with the Employer

Group 2

All other full-time non-exempt employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be regularly scheduled to work at least 30 hours per week.

WAITING PERIOD:

For employees in an eligible group on or before February 1, 2019: First of the month coincident with or next following 6 months of continuous active employment

For employees entering an eligible group after February 1, 2019: First of the month coincident with or next following 6 months of continuous active employment

REHIRE:

If your employment ends and you are rehired within 6 months, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

CREDIT PRIOR SERVICE:

Unum will apply any prior period of work with your Employer toward the waiting period to determine your eligibility date.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

7 days for disability due to an injury

7 days for disability due to a sickness

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:**Group 1**

60% of weekly earnings to a maximum benefit of \$1,750 per week

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

Group 2

60% of weekly earnings to a maximum benefit of \$750 per week

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

MAXIMUM PERIOD OF PAYMENT:

12 weeks

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

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

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of \$250 per week.

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.

OTHER FEATURES:

Minimum Benefit

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

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. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

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

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

HOW DO YOU FILE A 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.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- the appropriate documentation of your weekly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any **hospital or institution** where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

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. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

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; and
- your receipt of deductible sources of income.

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.

EMPLOYER PROVISIONS

WHAT DOES THIS SUMMARY OF BENEFITS CONSIST OF FOR THE EMPLOYER?

This Summary of Benefits consists of:

- all Summary of Benefits provisions and any amendments and/or attachments issued;
- each employee's application for insurance (employee retains his own copy); and
- the certificate of coverage issued for each employee of the Employer.

This Summary of Benefits may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this Summary of Benefits. No other person, including an agent, may change this Summary of Benefits or waive any part of it.

This Summary of Benefits is a part of the Policy issued to the Policyholder, is subject to provisions of, and cannot continue absent the Policy.

WHAT IS THE COST OF THIS INSURANCE?

SHORT TERM DISABILITY

The initial premium for each **plan** is based on the initial rate(s) shown in the Rate Information Amendment(s).

Premium payments are required for an insured while he or she is receiving Short Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS SUMMARY OF BENEFITS?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The **Employer** must send all premiums to the Policyholder who, in turn, must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE EMPLOYER?

The Employer must provide Unum with the following on a regular basis:

- information about employees:
 - who are eligible to become insured;
 - whose amounts of coverage change; and/or
 - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Both the Policyholder and the Employer are responsible for ensuring that Policyholder and Employer records that, in Unum's opinion, have a bearing on this Summary of Benefits will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS SUMMARY OF BENEFITS OR A PLAN UNDER THIS SUMMARY OF BENEFITS?

This Summary of Benefits or a plan under this Summary of Benefits can be cancelled:

- by Unum;
- by the Employer; or
- by the Policyholder.

Unum may cancel or modify this Summary of Benefits or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer or the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Employer or the Policyholder fails to perform any of its obligations that relate to the Policy or this Summary of Benefits;
- fewer than 10 employees are insured under this Summary of Benefits or a plan under this Summary of Benefits;
- the premium is not paid in accordance with the provisions of this Summary of Benefits that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer or the Policyholder does not promptly report to Unum 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 Employer and/or its employees; or
- the Employer fails to send to the Policyholder or the Policyholder fails to remit to Unum any portion of the premium within the 90 day **grace period**.

If Unum cancels or modifies this Summary of Benefits or a plan for reasons other than the Employer's and/or the Policyholder's failure to pay premium, a written notice will be delivered to the Employer and the Policyholder at least 31 days prior to the cancellation date or modification date. The Employer and/or the Policyholder may cancel this Summary of Benefits or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

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

If this Summary of Benefits or a plan is cancelled, the cancellation will not affect a **payable claim** incurred during the term of this Summary of Benefits.

An Employer's Summary of Benefits will terminate and coverage will end at 12:00 midnight on the day that:

- the Policy issued to the Policyholder terminates; or
- an Employer's membership in the Policyholder is discontinued or terminated; or
- an Employer's participation in the Policy is discontinued or terminated; or
- an Employer's eligibility to participate in the Policy ends.

WHO CAN CANCEL OR MODIFY THE POLICY?

The Policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify the Policy if:

- the Policyholder fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of information that is reasonably required; or
- the Policyholder fails to perform any of its obligations that relate to the Policy; or
- the Policyholder does not promptly report to Unum the names of Employers who become or are removed as Employers under the Policy; or
- the Policyholder fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of names of any employees who are added or deleted from the eligible group; or

- the Policyholder fails to take reasonable steps to facilitate the Employers' payment of any premium within the 90 day grace period.

If Unum cancels or modifies the Policy, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder will notify each Employer in writing in advance of the date of cancellation. The Policyholder may cancel the Policy if the modifications are unacceptable.

If any portion of an Employer's premium is not paid during the grace period, the Summary of Benefits of that Employer will terminate automatically at the end of the grace period. Each Employer is liable for premium for coverage under its Summary of Benefits during the grace period. All premium due for the full period each Employer's Summary of Benefits is in force must be paid to Unum.

The Policyholder may cancel the Policy or an Employer's Summary of Benefits by providing Unum written notice at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, the Policy or an Employer's Summary of Benefits can be cancelled on an earlier date. In either event, the Policyholder will notify each Employer in writing in advance of the date of cancellation.

If Unum or the Policyholder cancels the Policy, coverage provided to each Employer will end at 12:00 midnight on the date of cancellation. If the Policy is cancelled, the cancellation will not affect a payable claim incurred during the term of the Policy.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS SUMMARY OF BENEFITS WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE FROM THE EMPLOYER?

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

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 the Employer's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

Refer to the contract file correspondence for a listing of names and locations approved by Unum.

CERTIFICATE SECTION

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 Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the Summary of Benefits.

The Summary of Benefits 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 Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

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

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

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if **evidence of insurability** is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

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 month that immediately follows the month in which your temporary layoff begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.

Massachusetts Residents

If you are not working due to a plant closing (as defined in Section 71A of Chapter 151A of the Massachusetts Insurance Statutes), and if premium is paid, you will be covered up to 90 days from the date you were no longer in active employment. If you become covered under any other group disability plan, your coverage under this Summary of Benefits or plan will end.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage 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 decrease.

WHEN DOES YOUR COVERAGE END?

Non-Massachusetts Residents

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits 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 except as provided under the covered layoff or leave of absence provision.

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

Massachusetts Residents

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits 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 except as provided under the covered layoff, leave of absence provision and plant closing provisions, or as noted below.

If you end employment, coverage will be extended for 31 days. But if you become eligible for any other group disability insurance or any other arrangement, this extension of coverage will end.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits 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 time proof of claim is required, unless otherwise provided under federal law.

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

Unum considers any statements you, your Employer or the Policyholder make in a signed application for coverage a representation and not a warranty. If any of the statements you, your Employer or the Policyholder 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.

We will use only statements made in a signed application as a basis for doing this.

If the Employer or the Policyholder gives us information about you that is incorrect, we will:

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

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you, your Employer and the Policyholder 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, and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits 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 Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

DOES THE POLICYHOLDER ACT AS YOUR AGENT OR UNUM'S AGENT?

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

SHORT TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are **limited** from performing the **material and substantial duties** of your **regular occupation** due to your **sickness or injury**; and
- you have a 20% or more loss in weekly earnings due to the same sickness or injury.

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.

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 be interviewed by an authorized Unum Representative.

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

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 7 days.

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

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

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.

After the elimination period, if you are disabled for less than 1 week, we will send you 1/5th of your payment for each day of disability.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

Group 1

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is \$1,750.
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**.

Group 2

1. Multiply your weekly earnings by 60%.
2. The maximum **weekly benefit** is \$750.
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**.

WHAT ARE YOUR WEEKLY EARNINGS?

"Weekly Earnings" means your gross weekly income from your Employer, not including shift differential, in effect just prior to your date of disability. It includes 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 does not include income received from commissions, bonuses, overtime pay 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 disabled and your weekly **disability earnings** are from 20% through 80% of your weekly earnings, you will receive payments based on the percentage of income you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability earnings from your weekly earnings.
2. Divide the answer in Item 1 by your weekly earnings. This is your percentage of lost earnings.
3. Multiply your weekly payment as shown above by the answer in Item 2.

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 we believe are necessary to substantiate your income.

HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?

If your disability earnings routinely fluctuate widely from week to week, Unum may average your disability earnings over the most recent 3 weeks to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless the average of your disability earnings from the last 3 weeks exceeds 80% of weekly earnings.

We will not pay you for any week during which disability earnings exceed 80% of weekly earnings.

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 Title 46, United States Code Section 688 (The Jones Act).
 - as disability income payments from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.
3. The amount that you receive as disability income payments under the Pennsylvania Motor Vehicle Financial Responsibility Law.
4. 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.

5. 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.

6. 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.

Unum will only subtract deductible sources of income which are payable as a result of the same disability.

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

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 6 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the 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 6 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; 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?

Unum will send you a payment each week up to the **maximum period of payment**. Your maximum period of payment is 12 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:

- when you are able to work in your regular occupation on a **part-time basis** but 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.
- attempt to commit or commission of a crime.

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 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 30 consecutive days or less.

If you return to work on the 31st 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 Summary of Benefits' provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the Unum plan.

SHORT TERM DISABILITY

OTHER BENEFIT FEATURES

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 Summary of Benefits' 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 working at least the minimum number of hours as described under Eligible Group(s) 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.

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 an Employer.

EMPLOYER means a participating member of the Policyholder, who is eligible, has elected and has been approved by Unum for coverage under the Policy issued to the Policyholder as named on the first page of a Summary of Benefits issued by Unum and in all amendments. It includes any divisions, subsidiary or affiliated company named in the Summary of Benefits.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

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.

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.

LIMITED means what you cannot or are unable to do.

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 Summary of Benefits.

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 as a physician for a claim that you send to us.

PLAN means a line of coverage under the Summary of Benefits.

POLICY means the group Policy issued to the Policyholder in which your Employer is a participating member.

POLICYHOLDER means Sagewell Healthcare Benefits Trust, named on the first page of the Policy, the first page of each Employer's Summary of Benefits and in all amendments.

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 Summary of Benefits. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Summary of Benefits. 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.

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.

ERISA

Additional Summary Plan Description Information

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

Name of Plan:

Sagewell Healthcare Benefits Trust Plan

Name and Address of Plan Sponsor:

The Plan is established and maintained by Sagewell Healthcare Benefits Trust on behalf of Caron Treatment Center, the Plan Sponsor
1501 Reedsdale Street
Suite 3005
Pittsburgh, Pennsylvania
15233-2341

Plan Identification Number:

- a. Plan Sponsor IRS Identification #: 23-3398131
- b. Plan #: 510

Type of Welfare Plan:

Disability Income

Type of Administration:

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

ERISA Plan Year Ends:

December 31

Plan Administrator, Name, Address, and Telephone Number:

Benefit Advisors Services Group (BASG)
1501 Reedsdale Street
Suite 3005
Pittsburgh, Pennsylvania
15233-2341
(800) 872-0277

Benefit Advisors Services Group (BASG) is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of**Legal Process on the Plan:**

Benefit Advisors Services Group (BASG)
1501 Reedsdale Street
Suite 3005
Pittsburgh, Pennsylvania
15233-2341

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

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 473781 001. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

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

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

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

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum;
- by the Employer; or
- by the Policyholder.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer or the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Employer or the Policyholder fails to perform any of its obligations that relate to the Policy or the Summary of Benefits;
- fewer than 10 employees are insured under the Summary of Benefits or a plan under the Summary of Benefits;

- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer or the Policyholder does not promptly report to Unum 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 Employer and/or its employees; or
- the Employer fails to send to the Policyholder or the Policyholder fails to remit to Unum any portion of the premium within the 90 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan for reasons other than the Employer's and/or Policyholder's failure to pay premium, a written notice will be delivered to the Employer and the Policyholder at least 31 days prior to the cancellation date or modification date. The Employer and/or the Policyholder may cancel the Summary of Benefits or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

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

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim incurred during the term of the Summary of Benefits.

An Employer's Summary of Benefits will terminate and coverage will end at 12:00 midnight on the day that:

- the Policy issued to the Policyholder terminates; or
- an Employer's membership in the Policyholder is discontinued or terminated; or
- an Employer's participation in the Policy is discontinued or terminated; or
- an Employer's eligibility to participate in the Policy ends.

CANCELLING OR MODIFYING THE POLICY

The Policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify the Policy if:

- the Policyholder fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of information that is reasonably required; or
- the Policyholder fails to perform any of its obligations that relate to the Policy; or

- the Policyholder does not promptly report to Unum the names of Employers who become or are removed as Employers under the Policy; or
- the Policyholder fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of names of any employees who are added or deleted from the eligible group; or
- the Policyholder fails to take reasonable steps to facilitate the Employers' payment of any premium within the 90 day grace period.

If Unum cancels or modifies the Policy, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder will notify each Employer in writing in advance of the date of cancellation. The Policyholder may cancel the Policy if the modifications are unacceptable.

If any portion of an Employer's premium is not paid during the grace period, the Summary of Benefits of that Employer will terminate automatically at the end of the grace period. Each Employer is liable for premium for coverage under its Summary of Benefits during the grace period. All premium due for the full period each Employer's Summary of Benefits is in force must be paid to Unum.

The Policyholder may cancel the Policy or an Employer's Summary of Benefits by providing Unum written notice at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, the Policy or an Employer's Summary of Benefits can be cancelled on an earlier date. In either event, the Policyholder will notify each Employer in writing in advance of the date of cancellation.

If Unum or the Policyholder cancels the Policy, coverage provided to each Employer will end at 12:00 midnight on the date of cancellation. If the Policy is cancelled, the cancellation will not affect a payable claim incurred during the term of the Policy.

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.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

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 Summary of Benefits. 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).

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION

We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION

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

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION

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

ACCESS TO INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you

through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION

If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS

If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US

For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

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unum.com

MK-1883 (06-2020)

NOTICE OF PROTECTION PROVIDED BY PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

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, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to \$300,000 (or \$500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:

- Up to \$300,000 in death benefits including up to \$100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):

- Up to \$500,000 for health benefit plans, with some exceptions.
- Up to \$300,000 for disability income benefits.
- Up to \$300,000 for long-term care insurance benefits.
- Up to \$100,000 for all other types of health insurance.

Individual annuities

- Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contractholder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

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 Pennsylvania when it issued the policy or contract
- If the person is provided coverage by the guaranty association of another state
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary information provided by this notice and on the Association's web site do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether

coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's web site are for general information purposes and should not be relied upon as legal advice.