

AMENDMENT NO. 2

This amendment forms a part of Group Identification No. 473781 003 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 deaths that occur and 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 003

**EFFECTIVE DATE OF
COVERAGE:** February 1, 2019

ANNIVERSARY DATE: July 1

GOVERNING JURISDICTION: Maine

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

Sagewell Healthcare Benefits Trust

**under the
Select Group Insurance Trust
Policy No. 292000**

**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

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

SAGEWELL HEALTHCARE BENEFITS TRUST

ORIGINAL PLAN EFFECTIVE DATE: February 1, 2019

EMPLOYER'S PLAN

EFFECTIVE DATE: February 1, 2019

IDENTIFICATION

NUMBER: 473781 003

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:

Premium Waiver: 9 months

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

2 x annual earnings

All amounts are rounded to the nearest multiple of \$1,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

On the plan anniversary following the date you have reached age 70, but not age 75, your amount of life insurance will be:

- 55% of the amount of life insurance you had prior to age 70; or
- 55% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

On the plan anniversary following the date you have reached age 75, but not age 80, your amount of life insurance will be:

- 36% of the amount of life insurance you had prior to your first reduction; or
- 36% of the amount of life insurance shown above if you become insured on or after age 75 but before age 80.

There will be no further increases in your amount of life insurance.

On the plan anniversary following the date you have reached age 80, but not age 85, your amount of life insurance will be:

- 27% of the amount of life insurance you had prior to your first reduction; or
- 27% of the amount of life insurance shown above if you become insured on or after age 80 but before age 85 .

There will be no further increases in your amount of life insurance.

On the plan anniversary following the date you have reached age 85 or more, your amount of life insurance will be:

- 21% of the amount life insurance you had prior to your first reduction ; or
- 21% of the amount of life insurance shown above if you become insured on or after age 85.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

\$250,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Continuity of Coverage

Portability

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

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

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

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, 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?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the **regular care** of a **physician**;
- 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 or any gainful 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.

If claim is based on death, proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to \$2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to \$1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least \$10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than \$10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

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

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

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

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

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

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

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.

The Summary of Benefits is a part of the Master Summary issued to Sagewell Healthcare Benefits Trust, is subject to provisions of, and cannot continue absent the Master Summary.

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

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

PREMIUM WAIVER

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 9 months. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

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 Sagewell Healthcare Benefits Trust 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 an insurance 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 plan year and the prior plan year. In the case of fraud, premium adjustments will be made for all plan 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 Sagewell Healthcare Benefits Trust and the Employer are responsible for ensuring that Sagewell Healthcare Benefits Trust 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 Sagewell Healthcare Benefits Trust.

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

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or

- the Employer or Sagewell Healthcare Benefits Trust does not promptly provide Unum with information that is reasonably required; or
- the Employer or Sagewell Healthcare Benefits Trust fails to perform any of its obligations that relate to the Master Summary or this Summary of Benefits;
- fewer than 10 employees are insured under this Summary of Benefits or a plan under this Summary of Benefits; or
- 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 the premiums; or
- the Employer or Sagewell Healthcare Benefits Trust does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- 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 Sagewell Healthcare Benefits Trust or Sagewell Healthcare Benefits Trust fails to remit to Unum any 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 Sagewell Healthcare Benefits Trust's failure to pay premium, a written notice will be delivered to the Employer and Sagewell Healthcare Benefits Trust at least 31 days prior to the cancellation date or modification date. The Employer and/or Sagewell Healthcare Benefits Trust may cancel this Summary of Benefits or 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 this Summary of Benefits or a 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 Sagewell Healthcare Benefits Trust 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 Employer and Unum agree or Sagewell Healthcare Benefits Trust and Unum agree, this Summary of Benefits or a plan can be cancelled on an earlier date. If Unum, Sagewell Healthcare Benefits Trust 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 Master Summary issued to Sagewell Healthcare Benefits Trust terminates; or
- an Employer's membership in Sagewell Healthcare Benefits Trust is discontinued or terminated; or
- an Employer's participation in the Master Summary is discontinued or terminated; or
- an Employer's eligibility to participate in the Master Summary ends.

WHO CAN CANCEL OR MODIFY THE MASTER SUMMARY?

The Master Summary can be cancelled:

- by Unum; or
- by Sagewell Healthcare Benefits Trust.

Unum may cancel or modify the Master Summary if:

- Sagewell Healthcare Benefits Trust fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of information that is reasonably required; or
- Sagewell Healthcare Benefits Trust fails to perform any of its obligations that relate to the Master Summary; or
- Sagewell Healthcare Benefits Trust does not promptly report to Unum the names of Employers who become or are removed as Employers under the Master Summary; or
- Sagewell Healthcare Benefits Trust 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
- Sagewell Healthcare Benefits Trust 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 Master Summary, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to Sagewell Healthcare Benefits Trust at least 31 days prior to the cancellation date or modification date. Sagewell Healthcare Benefits Trust will notify each Employer in writing in advance of the date of cancellation. Sagewell Healthcare Benefits Trust may cancel the Master Summary 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.

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

If Unum or Sagewell Healthcare Benefits Trust cancels the Master Summary, coverage provided to each Employer will end at 12:00 midnight on the date of cancellation.

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

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 latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee 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; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

None

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. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

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 later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if **evidence of insurability** is required.

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 evidence of insurability form, 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 NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

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.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or 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 due to a change in your annual earnings or due to a plan change 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?

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 unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

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 or your authorized representative can start legal action regarding a 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 Sagewell Healthcare Benefits Trust make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you, your Employer or Sagewell Healthcare Benefits Trust 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 or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer or Sagewell Healthcare Benefits Trust 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 Sagewell Healthcare Benefits Trust do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE 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 the 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 SAGEWELL HEALTHCARE BENEFITS TRUST ACT AS YOUR AGENT OR UNUM'S AGENT?

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

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "**BENEFITS AT A GLANCE**" page.

WHAT ARE YOUR ANNUAL EARNINGS?

"Annual Earnings" means your gross annual income from your Employer, not including shift differential, in effect just prior to the date of loss. 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 ANNUAL 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 annual earnings from your Employer in effect just prior to the date your absence began.

WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?

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

Your elimination period is 9 months.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer

may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

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 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.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- \$10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 75% of

your life insurance amount. However, the one-time benefit paid will not be greater than \$500,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit is available on a voluntary basis. Therefore, you are not eligible for benefits if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Summary of Benefits subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits, except that the portable insurance coverage terms of this Summary of Benefits will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or

- 5x your annual earnings; or
- \$750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is \$5,000. If the current amounts under the plan are less than \$5,000, you may port the lesser amounts.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

APPLYING FOR PORTABLE COVERAGE

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which your Sagewell Healthcare Benefits Trust participates); or
- you failed to pay the required premium under the terms of this plan.

APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE

You may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below \$5,000. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE "**BENEFITS AT A GLANCE**" page.

WHEN PORTABLE COVERAGE ENDS

Portable coverage for you will end for the following reasons:

- the date you fail to pay any required premium; or
- the date the policy is cancelled (the Policy is the group policy issued to the Trustees of the Select Group Insurance Trust in which Sagewell Healthcare Benefits Trust participates).

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

PREMIUM RATE CHANGES FOR PORTABLE COVERAGE

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE

If you are not eligible to apply for portable coverage or portable coverage ends, then you may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

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.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with an Employer.

EMPLOYER means a participating member of Sagewell Healthcare Benefits Trust, who is eligible, has elected and has been approved by Unum for coverage under the Master Summary issued to Sagewell Healthcare Benefits Trust as named on the first page of a Summary of Benefits issued by Unum and in all amendments. It includes any division, 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.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

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

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. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

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.

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

MASTER SUMMARY means the group Master Summary issued to Sagewell Healthcare Benefits Trust in which your Employer is a participating member.

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.

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.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.

SAGEWELL HEALTHCARE BENEFITS TRUST means the Applicant named in the Application for Participation in the Select Group Insurance Trust and who is named on the first page of the Master Summary, the first page of each Employer's Summary of Benefits and in all amendments.

SELECT GROUP INSURANCE TRUST means the policyholder trust named on the first page of the Master Summary and the first page of each Employer's Summary of Benefits.

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.

YOU means an employee who is eligible for Unum coverage.

GROUP LIFE

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.

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue.

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 **HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The **WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?** provision in the **Life Insurance Benefit Information** section of the policy is amended to limit the suicide exclusion to 12 months after the effective date of coverage or the date any increases or additional insurance becomes effective.

For residents of Connecticut:

The **WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusion for

use of drugs, poisons, fumes or other chemical substances and amended to restate the crime or felony exclusion to read, "an attempt to commit or commission of a felony."

For residents of Illinois:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by."

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the phrase "contributed to by" and by limiting the application of the drug and chemical substance exclusion to "voluntary" use of a prescription or non prescription drug, poison, fume or other chemical substance.

For residents of Louisiana:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered from live birth until age 21 or such older age as stated in the policy.

For residents of Minnesota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to include the additional right to continue coverage for up to 18 months at no more than 102% of the cost of your coverage under the group policy if your coverage terminates or you are laid off.

The ***PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy, if applicable, are amended to provide that you may continue your coverage in the amount you are insured for under the group policy. However, the amount of your ported life insurance must be equal to or greater than the amount of your ported accidental death and dismemberment insurance.

The ***PREMIUM RATE CHANGES FOR PORTABLE COVERAGE*** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide that Unum may not change rates until your or your dependents' ported coverage has been in effect for 18 months.

The ***WHAT HAPPENS IF Unum OVERPAYS YOUR CLAIM?*** in the **LIFE INSURANCE CLAIM INFORMATION** section of the policy and the ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** in the **GENERAL**

PROVISIONS section of the policy are amended by deleting all references to fraud and the provision **HOW WILL Unum HANDLE INSURANCE FRAUD?** in the **GENERAL PROVISIONS** section of the policy is removed.

For residents of Montana:

The **WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of New Hampshire:

The **WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The **HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

For residents of New York:

The **APPLYING FOR PORTABLE COVERAGE** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE OTHER BENEFIT FEATURES** section of the policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

The **WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy and **APPLYING FOR PORTABLE COVERAGE** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **AD&D INSURANCE OTHER BENEFIT FEATURES** section of the policy, are amended to provide you have 90 days to convert or port your coverage from the date your life insurance terminates, or if the employer notifies you of your conversion or port rights within 90 days, 45 days from the date of that notice.

The **WHAT SEATBELT(S) AND AIRBAG BENEFIT WILL Unum PROVIDE?** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that the driver must have a valid driver's license.

The **WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?** provision in the **AD&D INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the exclusion for being intoxicated.

For residents of North Carolina:

The **APPLYING FOR PORTABLE COVERAGE** provision in the **LIFE INSURANCE OTHER BENEFIT FEATURES** section of the policy and the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE OTHER BENEFIT FEATURES** section of the

policy is amended by removing the prohibition on porting coverage if you, your spouse or your dependent are injured or sick.

For residents of North Dakota:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide exclusion to 12 months after the effective date of coverage.

The **SICKNESS** definition in the **GLOSSARY** section of the policy is amended to mean an illness or disease.

For residents of Oklahoma:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to limit the suicide and self inflicted injury exclusion to suicide while sane or insane.

For residents of Oregon:

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that in the event of death by suicide during the suicide exclusion period, a refund of premiums will be made.

For residents of Pennsylvania:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

The ***HOW MUCH WILL Unum PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR YOUR DEPENDENT'S ACCIDENTAL DEATH OR FOR CERTAIN OTHER COVERED LOSSES?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the requirement that for a claim to be payable, a death that results from an accidental bodily injury must occur within 365 days from the date of the accident.

For residents of South Carolina:

The ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage.

The ***WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?*** provision in the **GENERAL PROVISIONS** section of the policy is amended to allow up to 6 years from the date proof of claim is required to start a legal action regarding your claim.

The war exclusion in the ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended to read, "participation in a war, declared or undeclared, or any act of war."

For residents of South Dakota:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by removing the \$10,000 limitation on the individual life policy maximum available.

The definition of **PHYSICIAN** in the **GLOSSARY** section of the policy is amended so that the limitation on the provision of physician services by family members reads as follows:

Unum will not recognize as a physician the claimant or any member of the claimant's family residing in the claimant's household.

The ***WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT INFORMATION** section of the policy is amended by deleting the exclusions for intoxication, operating a vehicle while intoxicated and use of a chemical substance.

For residents of Texas:

The ***WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?*** provision in the **GENERAL PROVISIONS** section of the policy is amended by providing that unmarried dependent children may be covered until age 26 or such older age as stated in the policy regardless of student status.

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 ***WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that your Employer must notify you of your right to convert

your coverage. You have 15 days from the date your Employer notifies you of your conversion privileges to convert your coverage. In addition, in no event will the time allowed for you to exercise the life conversion privilege be extended beyond 90 days from the date your life insurance terminates.

For residents of Washington:

The **ACTIVE EMPLOYMENT** definition in the **GLOSSARY** section of the policy is amended to include the following:

A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The ***WILL Unum ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)*** in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to remove any exclusion for death caused by suicide.

For residents of West Virginia:

The ***WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended so that the period of time you must be insured under the plan is 3 years.

For residents of Wisconsin:

The ***HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?*** provision in the **GENERAL PROVISIONS** section of the policy is amended so that after your coverage has been in force for two (2) or more years your coverage may not be rescinded for any reason.

The ***WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?*** provision in the **LIFE INSURANCE BENEFIT INFORMATION** section of the policy is amended to provide that once your waiver claim is approved, premium waiver is retroactive to the end of the elimination period.

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:

Life

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 003. 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 Sagewell Healthcare Benefits Trust.

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

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

- 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 the premiums; or
- the Employer or Sagewell Healthcare Benefits Trust does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- 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 Sagewell Healthcare Benefits Trust or Sagewell Healthcare Benefits Trust fails to remit to Unum any 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 Sagewell Healthcare Benefits Trust's failure to pay premium, a written notice will be delivered to the Employer and Sagewell Healthcare Benefits Trust at least 31 days prior to the cancellation date or modification date. The Employer and/or Sagewell Healthcare Benefits Trust may cancel the Summary of Benefits or 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 a 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 Sagewell Healthcare Benefits Trust 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 Employer and Unum agree or Sagewell Healthcare Benefits Trust and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum, Sagewell Healthcare Benefits Trust 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 Master Summary issued to Sagewell Healthcare Benefits Trust terminates; or
- an Employer's membership in Sagewell Healthcare Benefits Trust is discontinued or terminated; or
- an Employer's participation in the Master Summary is discontinued or terminated; or
- an Employer's eligibility to participate in the Master Summary ends.

MODIFYING OR CANCELLING THE MASTER SUMMARY

The Master Summary can be cancelled:

- by Unum; or
- by Sagewell Healthcare Benefits Trust.

Unum may cancel or modify the Master Summary if:

- Sagewell Healthcare Benefits Trust fails to take reasonable steps to facilitate the Employers' prompt provision to Unum of information that is reasonably required; or
- Sagewell Healthcare Benefits Trust fails to perform any of its obligations that relate to the Master Summary; or
- Sagewell Healthcare Benefits Trust does not promptly report to Unum the names of Employers who become or are removed as Employers under the Master Summary; or
- Sagewell Healthcare Benefits Trust 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
- Sagewell Healthcare Benefits Trust 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 Master Summary, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to Sagewell Healthcare Benefits Trust at least 31 days prior to the cancellation date or modification date. Sagewell Healthcare Benefits Trust will notify each Employer in writing in advance of the date of cancellation. Sagewell Healthcare Benefits Trust may cancel the Master Summary 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.

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

If Unum or Sagewell Healthcare Benefits Trust cancels the Master Summary, coverage provided to each Employer will end at 12:00 midnight on the date of cancellation.

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

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

If a claim is based on death

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

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

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

If a claim is based on your disability

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

If an appeal is based on death

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

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

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

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

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.

If an appeal is based on your disability

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.

**Addendum to the "Additional Summary Plan Description Information"
included with your certificate of coverage or summary of benefits
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 summary of benefits 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

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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.