Cadence Design Systems, Inc.

Your Group Long Term Care Insurance Plan

Policy No. 220521

Underwritten by Unum Life Insurance Company of America

05-2020

This Certificate of Insurance is a part of the entire contract. This certificate is subject to the terms and conditions stated on the attached pages, all of which are part of the Summary of Benefits. The Summary of Benefits is a part of the Select Group Insurance Trust sitused in Maine. Maine National Bank is the Trustee.

Group Identification Number: 220521

- Insured persons are entitled to examine a copy of the Summary of Benefits during regular office hours at the Employer's place of business.
- Insured persons also are entitled to examine a copy of the Master Policy by contacting UNUM directly.
- Throughout this certificate:
  - "you" or "your" means an active employee who is eligible for UNUM benefits.

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

    - the spouse of an active employee (you must be legally married to your spouse),
    - the natural, adoptive or step-parents/grandparents of an active employee, or
    - the natural, adoptive or step-parents/grandparents of a spouse of an active employee, or
    - the domestic partner of an active employee.
  - UNUM means UNUM Life Insurance Company of America, and
  - Employer means Cadence Design Systems, Inc. and the following divisions, subsidiaries, and affiliated companies of Cadence Design Systems, Inc.:

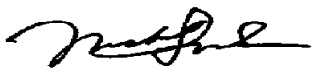
NONE

- You have a 30 day right to examine this certificate.

  If, after examining this certificate, you are not satisfied for any reason, you may withdraw your enrollment in this plan by returning this certificate within 30 days of its delivery to you. The certificate, together with a written request for such withdrawal, must be sent to:

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

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



President

TABLE OF CONTENTS

HIGHLIGHTS OF THE LONG TERM CARE INSURANCE PLAN

Eligibility and participation	You are eligible for the plan if you are an active employee of the Employer or one of the following divisions, subsidiaries or affiliated companies of the Employer: NONE Your family members are also eligible for the plan. Family members include your: • spouse (you must be legally married to your spouse), • natural, adoptive or step-parents/ grandparents, or • spouse's natural, adoptive or step-parents/grandparents, or • the domestic partner of an active employee. Temporary or seasonal employees are excluded.

Schedule of Long Term Care Benefits

BASE COVERAGE

Residence	**Monthly Benefit Amount**
Long Term Care Facility	Amounts in $1,000 units as applied for by you and approved by UNUM. . Minimum - 1 unit ($1,000) . Maximum - 5 units ($5,000)
Residential Care Facility	An amount equal to 60% of your Long Term Care Facility amount.

AVAILABLE OPTIONS

Residence	**Monthly Benefit Amount**
Home or another similar place	
- Total Home Care	An amount equal to 50% of your "Long Term Care Facility" amount.
Inflation Protection	
- Simple Growth	

The Lifetime Maximum Amount payable is:

36 X the "Long Term Care Facility" amont.	72 X the "Long Term Care Facility" amount.	Unlimited

Elimination Period is 90 consecutive days.

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

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

INTRODUCTION TO THE UNUM PLAN

WHAT IS THE UNUM PLAN?

The Unum plan provides long term care insurance for you.

WHAT IS LONG TERM CARE INSURANCE?

Long term care insurance gives financial help in case you need care in a long term care facility, at home or another similar place.

WHAT CAN YOU RECEIVE FROM LONG TERM CARE INSURANCE?

Insurance for long term care pays you a monthly payment for a loss of functional capacity or cognitive impairment. The amount of the monthly payment will depend on:

- the long term care plan of coverage you choose;
- any options you choose, if available; and
- the place of residence used for long term care.

What is a loss of functional capacity?

A loss of functional capacity means a loss of 2 or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness or because of advanced age. Two or more ADL losses must occur while you are insured for long term care insurance.

What is a sickness?

A sickness means illness, disease or physical condition which causes a loss of functional capacity beginning while your insurance is in force and which is not excluded.

What are activities of daily living?

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

- **BATHING** means cleaning the body using a tub, shower, or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, and reaching head and body parts for soaping, rinsing, and drying.
- **DRESSING** means putting on, taking off, fastening, and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings or garments, and artificial limbs or splints.
- **TOILETING** means getting on and off the toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

- **TRANSFERRING** means moving from one sitting or lying position to another sitting or lying position; for example, from bed to or from a wheelchair or sofa, coming to a standing position, or repositioning to promote circulation and prevent skin breakdown.

- **CONTINENCE** means the ability to control bowel and bladder as well as use ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

- **EATING** means reaching for, picking up, and grasping a utensil and cup; getting food on a utensil, and bringing food, utensil and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals.

- **AMBULATING** means walking or moving around inside or outside the home regardless of the use of a cane, crutches, or braces.

What is standby assistance?

Standby assistance means that, in the absence of another person's assistance, you would not be able to safely and completely perform an activity of daily living. Stand-by assistance also means that you may need verbal cueing in order to accomplish an activity of daily living or to ensure your safety in accomplishing an activity of daily living.

What is cognitive impairment?

Cognitive impairment means a deterioration or loss in intellectual capacity resulting from Alzheimer's disease or similar forms of irreversible dementia.

The extent of your cognitive impairment will be determined by clinical evidence and standardized tests which reliably measure your deterioration or loss in the following areas:

- short or long term memory;

- orientation as to:

  - person (such as who you are);

  - place (such as your location);

  - time (such as day, date and year); and

- deductive or abstract reasoning.

If, because of a deterioration or loss in intellectual capacity, you need continual supervision for your own protection or for the protection of others, Unum will consider you to have cognitive impairment.

WHO PAYS FOR LONG TERM CARE INSURANCE?

The coverage under this plan is contributory. This means you pay the full cost of your coverage under Unum's long term care insurance.

How is the cost determined?

The rate you pay over the duration of your initial coverage or for any increases is based on your insurance age. To determine insurance age:

IF APPLYING FOR INITIAL COVERAGE ON OR BEFORE PLAN EFFECTIVE DATE	IF APPLYING FOR INITIAL COVERAGE OR FOR ANY CHANGE IN COVERAGE AFTER PLAN EFFECTIVE DATE
Subtract year of birth from the year the plan is effective.	Subtract year of birth from the year of the application for the initial coverage or for each change in coverage.

The rate will not increase because you grow older or because of your use of the benefits. However, the rate schedule may change in the future depending on the overall use of the benefits of all covered persons or changes in the benefit levels, plan design or other risk factors. Any such change will be made on a class basis according to Unum's underwriting risk studies under this type of insurance.

How do you pay the premiums?

- If you are an active employee, the spouse of an active employee, or the domestic partner of an active employee:

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

- If you are the natural, adoptive or step-parents/grandparents of an active employee, or the natural, adoptive or step-parents/grandparents of the spouse of an active employee

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

Is there a grace period?

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

Will premiums be waived while you are receiving a monthly payment?

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

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

  - have a loss of functional capacity or cognitive impairment; and
  - reside in a Long Term Care Facility.

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

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

  - have a loss of functional capacity or cognitive impairment; and
  - reside in a Residential Care Facility.

- **If you are receiving a "Professional Home Care" monthly payment:**

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

  - have a loss of functional capacity or cognitive impairment; and
  - receive Professional Home Care.

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

- **If you are receiving a "Total Home Care" monthly payment:**

  When benefits become payable, there will be no more cost for your coverage as long as you continue to have a loss of functional capacity or cognitive impairment.

WHO IS ELIGIBLE FOR THE PLAN?

Persons who may be eligible for the plan are:

Active employees of the Employer and their family members.

What is an active employee?

An active employee means that you elected coverage prior to February 1, 2024, and are working for the Employer:

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

Temporary or seasonal employees are excluded.

What is a family member?

A family member means:

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

NOTE:

Your domestic partner is the person named in your declaration of domestic partnership. You must execute and provide the plan administrator with such a declaration which states and gives proof that the domestic partner has had the same permanent residence as you for a minimum of 12 consecutive months prior to the date insurance would become effective for the domestic partner. You must not have signed a declaration of domestic partnership with anyone else within the last 12 months of signing the latest declaration of domestic partnership. Also, the domestic partner must be at least 18 years of age, competent of contract, not related by blood closer than would bar marriage, the sole named domestic partner, not married to anyone else and the declaration of domestic partnership must be approved and recorded by the plan administrator.

You may not cover your domestic partner as a dependent if your domestic partner is enrolled for coverage as an employee.

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

When do you become eligible?

You will be eligible for coverage on the date you enter an eligible class.

When can you apply for coverage?

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

- **During your first enrollment period,** you can apply for coverage without evidence of insurability.
- **After your first enrollment period,** you can apply for coverage with evidence of insurability.

How do you apply for coverage?

- **During your first enrollment period:**

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

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

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

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

- **After your first enrollment period:**

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

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

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

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

What is evidence of insurability?

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

What is an insurability assessment?

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

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

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

When do you become eligible?

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

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

When can you apply for coverage?

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

How do you apply for coverage?

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

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

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

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

WHEN DOES COVERAGE BEGIN?

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

  - **Coverage applied for within your first enrollment period** will begin on the latest of these dates:

    - the plan effective date,

    - 12:01 a.m. on the first day of the month that occurs on or next follows the month in which you become eligible for coverage, or

    - 12:01 a.m. on the first day of the month that occurs on or next follows the date you applied for coverage.

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

- **If you are a family member:**

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

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

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

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

Coverage will not begin for you if you are absent from work because you are injured, sick, temporarily laid off or on a leave of absence on the date that the coverage would normally begin.

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

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

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

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

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

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

What if the Employer rehires you?

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

However, if:

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

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

CAN COVERAGE BE CHANGED?

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

When will the changes take effect?

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

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

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

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

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

WHEN WILL GROUP COVERAGE THROUGH THE PLAN END FOR YOU?

When will coverage end?

Your coverage will end on the earliest of these dates:

- the date the Summary of Benefits under the policy ends,
- the date you no longer are in an eligible class,
- the date your class no longer is included for insurance,
- the end of the period for which premiums were last remitted to UNUM for your coverage, or
- the date you no longer are an active employee with the Employer.

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

What if you are absent from work at Cadence Design Systems, Inc.?

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

What happens when group long term care coverage ends?

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

But, if you voluntarily end your group long term care coverage, you may not elect portable coverage.

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

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

Also, the rate schedule for portable coverage may change in the future, depending on the overall use of the benefits by all covered persons or changes in the benefit levels or other risk factors. Any such change will be made on a class basis according to UNUM's underwriting risk studies.

Can coverage be changed once on portability?

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

LONG TERM CARE INSURANCE

WHAT ARE LONG TERM CARE BENEFITS?

A long term care benefit will be paid to you for a loss of functional capacity or cognitive impairment according to the following schedule of long term care benefits:

BASE COVERAGE

Residence	**Monthly Benefit Amount**
Long Term Care Facility	Amounts in $1,000 units as applied for by you and approved by UNUM. . Minimum - 1 unit ($1,000) . Maximum - 5 units ($5,000)
Residential Care Facility	An amount equal to 60% of your Long Term Care Facility amount.

AVAILABLE OPTIONS

Residence	**Monthly Benefit Amount**
Home or another similar place	
- Total Home Care	An amount equal to 50% of your "Long Term Care Facility" amount.

Inflation Protection

- Simple Growth

The Lifetime Maximum Amount payable is:

36 X the "Long Term Care Facility" amont.	72 X the "Long Term Care Facility" amount.	Unlimited

What is a Long Term Care Facility?

A Long Term Care Facility is:

- an institution, or a distinctly separate part of a hospital, that provides skilled, intermediate or custodial care and operates under state licensing laws and any other laws that apply;
- any other institution that meets all of the following tests:
  - is operated as a health care facility under applicable state licensing laws and any other laws;
  - primarily provides nursing care under the orders of a doctor;
  - operates under the supervision of a registered nurse or a licensed practical nurse;
  - regularly provides room and board and continuous 24 hour a day nursing care of sick and injured persons;
  - maintains a daily medical record of each patient who must be under the care of a doctor;
  - is authorized to administer medication to patients on the order of a doctor; and
  - is not, other than incidentally:
    - a home for the mentally retarded, the mentally ill, the blind or the deaf, alcoholics or drug abusers, or
    - a hotel, a domiciliary care home or a residence; or
- a similar institution approved by Unum.

The confinement must be:

- prescribed or recommended by a doctor, and
- recommended, at least annually during the confinement, by your doctor as necessary due to a loss of functional capacity or cognitive impairment.

What is a Residential Care Facility?

Residential Care Facility means:

- a facility licensed as a residential care facility for the elderly or a residential care facility as defined in the Health and Safety Code; or
- facilities that meet applicable licensure standards, if any, that:
  - are engaged primarily in providing ongoing care and related services sufficient to support needs resulting from impairment in Activities of Daily Living or impairment in cognitive ability;
  - provides care and services on a 24-hour basis;

- has a trained and ready-to-respond employee on duty in the facility at all times to provide care and services;
- provides three meals a day and accomdates special dietary needs;
- has agreements to ensure that residents receive medical care services of a doctor or nurse in case of emergency; and
- has appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications; or

• a similar institution approved by Unum.

What is Professional Home Care?

Professional Home Care means:

- Skilled nursing care; physical, respiratory, occupational, dietary or speech therapy; and homemaker services provided by a Home Health Care Provider; and
- Adult Day Care provided by:
  - a Home Health Care Provider; or
  - an Adult Day Care Facility which meets the following tests:

    The Adult Day Care Facility must:
    - Operate a minimum of 5 days a week;
    - Remain open for at least 6 hours a day;
    - Not be an overnight facility;
    - Maintain a written record of care on each patient;
    - Include a plan of care and record of services provided;
    - Have a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
    - Have established procedures for obtaining appropriate aid in the event of a medical emergency; and
    - Provide a range of physical and social support services to adults.

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

What is a Home Health Care Provider?

A Home Health Care Provider is:

- an organization which is licensed or certified by the appropriate licensing agency of the state where Professional Home Care will be provided; or
- certified as a home health care organization as defined under Medicare; or
- any other organization that meets all of the following tests:
  - primarily provides skilled nursing care and other therapeutic services;
  - has standards, policies and rules established by a professional group which is associated with the organization;
  - includes at least one doctor and one registered nurse;
  - maintains a written record of care on each patient; and
  - includes a plan of care and record of services provided; or
- a similar organization approved by Unum.

What is Total Home Care?

Total Home Care provides financial help in case you need care at home or another similar place due to a loss of functional capacity or cognitive impairment.

Care may be provided to you by:

- a formal caregiver, such as a Home Health Care Provider, an Adult Day Care Facility, a registered nurse, a licensed practical nurse, etc., or
- an informal caregiver, such as your friends or relatives.

What is the Elimination Period?

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

The Elimination Period under the Summary of Benefits for this certificate is 90 consecutive days.

- **If you are receiving "Professional Home Care",** each calendar week that you receive at least one day of Professional Home Care will be counted as seven days towards completing the Elimination Period.

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

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

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

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

The Lifetime Maximum Amount under the Summary of Benefits for this certificate is unlimited.

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

Yes.

- **If you choose the inflation option at the time of enrollment,** your coverage will be increased by 5% of your initial amount on January 1st of the next calendar year. Subsequent 5% increases will:

  - be added, each January 1st after that, to your initial amount of coverage; and

  - continue to occur until your amount of coverage has been increased to 200% of your initial amount of coverage.

- **If you choose the inflation option when you apply for additional coverage,** your additional coverage will be increased by 5% of your additional amount on January 1st of the next calendar year. Subsequent 5% increases will:

  - be added, each January 1st after that, to your additional amount of coverage; and

  - continue to occur until your additional amount of coverage has been increased to 200% of your additional amount of coverage.

- **FOR EXAMPLE:** A monthly benefit amount of $1,000 will be increased by $50 each calendar year until the amount of coverage equals $2,000 which is 200% of the beginning monthly benefit amount.

As long as your coverage remains in effect, these inflation increases will occur automatically regardless of your health or whether or not you have suffered a loss of functional capacity or cognitive impairment.

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

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

To qualify to receive monthly payments from Unum:

- **If you are residing in a Long Term Care Facility or Residential Care Facility, you must:**

  - suffer a loss of functional capacity as the result of an injury or a sickness or because of advanced age, or

  - suffer cognitive impairment as the result of Alzheimer's disease or a similar form of irreversible dementia

  while insured for a "Long Term Care Facility" or "Residential Care Facility" amount under this long term care insurance;

  - be under the regular care of a doctor according to the condition; and

  - give Unum proof that you have suffered a loss of functional capacity or cognitive impairment.

- **If you are residing at home or another similar place, you must:**

  - suffer a loss of functional capacity as the result of an injury or a sickness or because of advanced age, or

  - suffer cognitive impairment as the result of Alzheimer's disease or a similar form of irreversible dementia

  while insured for a "Professional Home Care" or "Total Home Care" amount under this long term care insurance;

  - be under the regular care of a doctor according to the condition;

  - be receiving Professional Home Care or Total Home Care; and

  - give Unum proof that you have suffered a loss of functional capacity or cognitive impairment.

<u>What is a doctor?</u>

A doctor is a person who is licensed to practice medicine and/or surgery and prescribe and administer drugs.

Unum will consider a person to be a doctor only when the person is performing tasks that are within the limits of the person's medical license.

Unum will not recognize:

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

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

WHEN WILL YOU RECEIVE MONTHLY PAYMENTS FOR LONG TERM CARE?

If you have completed the Elimination Period, Unum's monthly payments will become payable on the day after you complete the Elimination Period.

Unum will not send any monthly payments to you if you have not completed the Elimination Period.

HOW MUCH WILL UNUM PAY IF YOU HAVE A LOSS OF FUNCTIONAL CAPACITY OR COGNITIVE IMPAIRMENT?

If you have a loss of functional capacity or cognitive impairment, Unum will send the payment to you each month. To determine the amount Unum will pay you each month see **"WHAT ARE LONG TERM CARE BENEFITS?"**.

If you are eligible for a "Long Term Care Facility" payment for a period that is less than one month, Unum will pay 1/30th of your "Long Term Care Facility" Monthly Benefit Maximum for each day that you:

- have a loss of functional capacity or cognitive impairment; and
- reside in a Long Term Care Facility.

If you are eligible for a "Residential Care Facility" payment for a period that is less than one month, Unum will pay 1/30th of your "Residential Care Facility" Monthly Benefit Maximum for each day that you:

- have a loss of functional capacity or cognitive impairment; and
- reside in a Residential Care Facility.

If you are eligible for a "Professional Home Care" payment for a period that is less than one month, Unum will pay 1/30th of your "Professional Home Care" Monthly Benefit Maximum for each day that you:

- have a loss of functional capacity or cognitive impairment; and
- receive Professional Home Care.

If you are eligible for a "Total Home Care" payment for a period that is less than one month, Unum will pay 1/30th of your "Total Home Care" Monthly Benefit Maximum for each day that you have a loss of functional capacity or cognitive impairment.

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

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

- the date you no longer have a loss of functional capacity or cognitive impairment,
- the date you die,
- the date you no longer qualify to receive a monthly payment under the long term care plan of coverage you chose, or
- the date your total benefit payments equal the Lifetime Maximum Amount.

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

Yes. If you qualify for a "Professional Home Care" or "Total Home Care" monthly payment but benefits have not yet become payable, Unum will make payments to you for each day you receive respite care for up to 15 days each year. The amount of your payment will equal 1/30th of your "Professional Home Care" or "Total Home Care" Monthly Benefit Maximum for each day that you receive respite care.

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

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

What is respite care?

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

This formal care includes:

- Skilled nursing care; physical, respiratory, occupational or speech therapy; and homemaker services provided by a Home Health Care Provider; and
- Adult Day Care provided by:
  - a Home Health Care Provider; or
  - an Adult Day Care Facility which meets the following tests:

  The Adult Day Care Facility must:
  - Operate a minimum of 5 days a week;
  - Remain open for at least 6 hours a day;
  - Not be an overnight facility;
  - Maintain a written record of care on each patient;
  - Include a plan of care and record of services provided;
  - Have a staff that includes a full-time director and at least one registered nurse who are there during operating hours for at least 4 hours a day;
  - Have established procedures for obtaining appropriate aid in the event of a medical emergency; and
  - Provide a range of physical and social support services to adults.

WHAT IF YOU HAVE A LOSS OF FUNCTIONAL CAPACITY OR COGNITIVE IMPAIRMENT AGAIN AFTER RECEIVING LONG TERM CARE PAYMENTS FROM UNUM?

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

WHAT IS NOT COVERED FOR LONG TERM CARE?

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

- losses caused by war (whether declared or not) or any act of war,
- losses caused by attempted suicide (while sane or insane) or self-destruction,
- losses caused by committing or attempting to commit an assault or felony,
- losses or confinements during which you are outside the United States, its territories or possessions for longer than 30 days,
- any day you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention),
- losses caused by alcoholism,
- losses caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you by a doctor. ("Controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- losses caused by psychological or psychiatric conditions which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia, or
  - manic depressive disorders

  whether treated by drugs, counseling or other forms of therapy.

  However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.

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

Unum will not make any payments to you for any loss of functional capacity or cognitive impairment that:

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

A preexisting condition is any condition that exists for which you:

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

during the six month period right before your coverage began.

Unum calls this a preexisting condition.

This preexisting conditions exclusion will apply to all insurance that does not require evidence of insurability.

CAN UNUM HELP YOU REGAIN FUNCTIONAL CAPACITY?

Unum may suggest that you participate in a case management or rehabilitation program designed to help regain the functional capacity to engage in the activities of daily living. The actual expenses that Unum will pay for and the terms of the case management or rehabilitation program will be subject to mutual agreement between Unum and you or your authorized representative. This agreement will be outlined in a written plan of case management or rehabilitation.

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

Unum considers any statements you make for insurance in a signed application to be complete and true to the best of your knowledge and belief. If any of these statements are not complete and/or not true at the time they are made, Unum can:

- reduce or deny any claim, or
- cancel insurance from the original effective date.

Unum must use only the statements made in the signed application as a basis for doing this.

Unum can take these actions only in the first 2 years your insurance is in force.

CAN THE EMPLOYER ACT AS UNUM'S AGENT?

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

CLAIM INFORMATION

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

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

If you do not have a Long Term Care Notice of Claim Form, you can get one from the Employer's Plan Administrator, or your Unum representative, or you can notify Unum in writing that you want to make a claim. If you do not receive the form from Unum within 15 days after writing, send Unum proof of the claim without the form.

You must send Unum proof of claim for long term care payments no later than 90 days after the end of the first monthly period for which you are eligible to receive long term care payments from Unum. If you cannot send Unum proof within this 90-day period, you must send Unum proof as soon as it is reasonably possible to do so, but in no event more than one year after the time proof is otherwise required.

The proof of your claim must tell Unum:

- what the loss of functional capacity or cognitive impairment is,
- the date that the loss of functional capacity or cognitive impairment began,
- the cause of the loss of functional capacity or cognitive impairment,
- the address of the place of residence used for long term care, and
- the name and address of your attending doctor(s).

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

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

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

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

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

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

Unum may also send your attending doctor(s) a Long Term Care Attending Physician's Initial Statement Form to fill out and send to Unum. In some cases, Unum may require additional Attending Physician's Progress Statements if you continue to have a loss of functional capacity or cognitive impairment.

After you have filed a claim, Unum may also require you to be examined by a doctor or other medical practitioner of Unum's choice. Unum will pay for the examination. Unum can require an examination as often as it is reasonable to do so.

Unum may require you or your authorized representative to give it authorization to obtain additional medical and nonmedical information as part of the proof of claim.

What is a claims assessment?

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

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

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

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

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

When Unum receives acceptable proof of your claim for long term care payments, Unum will begin to send you long term care payments if you have satisfied any applicable Elimination Period.

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

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

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

IMPORTANT INFORMATION FOR CONNECTICUT RESIDENTS

ENDORSEMENT TO CERTIFICATE OF INSURANCE

If you were a resident of Connecticut when your coverage under the Group Summary of Benefits first became effective, and if the provisions referenced below appear in your Certificate of Insurance in a form less favaorable to you as an insured, they are change as follows:

1) The "**WHAT IS NOT COVERED FOR LONG TERM CARE?**" section is changed to state:

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

- losses caused by war (whether declared or not) or any act of war,
- losses caused by attempted suicide (while sane or insane) or self-destruction,
- losses caused by the commission of a felony for which you have been convicted under state or federal law,
- losses or confinements during which you or your spouse is outside the United States, its territories or possessions for longer than 30 days,
- any day you or your spouse is confined in any facility for acute care (acute care is medical care obtained as a result of an injury or sickness requiring immediate medical intervention),
- confinement in a facility for which no charge is normally made in the absence of insurance, except Medicaid,
- losses caused by a confinement due to alcoholism or drug addiction,
- losses caused by voluntary use of any controlled substance unless the controlled substance is prescribed for you or your spouse by a doctor. ("controlled substance" is defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments.), or
- losses caused by psychological or psychiatric or mental conditions, regardless of cause, which include:
  - depression,
  - generalized anxiety disorders,
  - personality disorders,
  - schizophrenia; or
  - manic depressive disorders.

  Whether treated by drugs, counseling or other forms of therapy.

However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infract dementia, or Parkinson's disease.

B.LTC AE-1188

2) The "**WILL UNUM MAKE ANY PAYMENT IF EITHER YOU OR YOUR SPOUSE HAD A CONDITION BEFORE UNUM'S LONG TERM CARE COVERAGE BEGINS?**" section is removed in its entirety and is no longer applicable:

Persons age 65 and over at the time of enrollment

Unum will not make any payments for any loss of functional capacity that:

- is caused by, contributed to by, or results from a preexisting condition, and
- begins during the first six (6) months after your or your spouse's coverage begins.

A preexisting condition is any condition that exists for which you or your spouse:

- received medical treatment, consultation, care, or services, including diagnostic measures for the condition, or
- took drugs or medicines that were prescribed for the condition, during the six (6) month period right before your or your spouse's coverage began.

Unum calls this a preexisting condition.

Persons under age 65 at the time of enrollment

Unum will not make any payments for any loss of functional capacity that:

- is caused by, contributed to by, or results from a preexisting condition, and
- begins during the first twelve months after your or your spouse's coverage begins.

3) "The **HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS INSURANCE BE USED?**" section is changed to state:

Unum considers any statements you make for insurance in a signed application to be complete and true to the best of your knowledge and belief. If any of these statements are not complete and/or true at the time they are made Unum can:

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

Unum must only use these statements made in the signed application as a basis for doing this.

Unum can take these actions only in the first two (2) years your insurance is inforce.

If your coverage has been inforce for two (2) years or more, your coverage may be cancelled only for non-payment of premium.

If we have paid benefits under the policy, the benefit payments may not be recovered by us in the event that coverage is cancelled.

Important: This document becomes part of your Certificate of Insurance. Be sure to keep this document in your records with the Certificate of Insurance previously provided to you under the group policy.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

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

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. Unum must receive a completed claim form. The form must be completed by you or your authorized representative. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIM PROCEDURES

The time periods provided in this section will apply to claims procedures under the Summary of Benefits unless a shorter time period is stated in the Summary of Benefits.

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

1. the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;

2. a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and

3. a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

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

APPEAL PROCEDURES

The time period provided in this section for submitting an appeal will apply unless a longer time period for submitting an appeal is stated in the Summary of Benefits.

The time period provided in this section for making a final appeal decision will apply unless a shorter time period for making a final appeal decision is stated in the Summary of Benefits.

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

1. submit a request for review, in writing, to Unum;

2. upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

3. submit written comments, documents, records and other information relating to the claim to Unum.

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

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

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. Unum and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligiblity for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in the evaluating those decisions.