Travis County Commissioners Court Agenda Request

Meeting Date: March 20, 2012
Prepared By/Phone Number: Elizabeth Corey (854-9853)
Elected/Appointed Official/Dept. Head: Cyd Grimes
Commissioners Court Sponsor: Judge Biscoe

Agenda Language: Approve contract award for Long Term Care insurance for Travis County employees, retirees, dependents and eligible family members, RFP No. P110080-OJ, to the sole bidder, Unum Life Insurance Company of America (Unum).

- **Purchasing Recommendation and Comments:** Purchasing concurs with department and recommends approval of requested action. This procurement action meets the compliance requirements as outlined by the statutes.
- This contract provides long term care insurance for Travis County employees, retirees, dependents and eligible family members.
- On February 10, 2011, Request for Proposal P110080-OJ was issued for long term care insurance coverage. One proposal was received on March 1, 2011, from Unum. The Human Resources Management Department (HRMD) analyzed the proposal, and Commissioners Court approved the plan on September 27, 2011. The initial enrollment period was from January 4 through February 15, 2012.
- **Contract Expenditures:** This benefit is 100% employee-paid. There is no fiscal impact to Travis County. Participants will be direct-billed by Unum.

- **Contract-Related Information:**
  Award Amount: N/A
  Contract Type: Bilateral
  Contract Period: April 1, 2012, renewing annually until terminated

AGENDA REQUEST DEADLINE: All agenda requests and supporting materials must be submitted as a pdf to Cheryl Aker in the County Judge's office, Cheryl.Aker@co.travis.tx.us **by Tuesdays at 5:00 p.m.** for the next week's meeting.

- **Solicitation-Related Information:**

  Solicitations Sent: 48 Responses Received: 1

  HUB Information: N/A % HUB Subcontractor: N/A

- **Funding Information:**
  - ☐ Purchase Requisition in H.T.E.: N/A
  - ☐ Funding Account(s): N/A
  - ☐ Comments:

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Human Resources Management Department

700 Lavaca Street, 4th Floor • P.O. Box 1748 • Austin, Texas 78701 • (512) 854-9165 / (512) 854-4302

March 9, 2012

To: Elizabeth Corey, Purchasing Dept
From: Cindy Purinton- Benefit Administrator, HRMD CP
Re: UNUM Long Term Care Contract

Elizabeth,

As we prepare to complete the process of contracting for Long Term Care insurance with UNUM I have prepared the following recommendation to proceed with the finalization of the contract with UNUM.

HRMD and the Benefit Committee recommend approval of the Long Term Care Contract with UNUM.
There is no County fund expenditure, it is 100% voluntary. This will be direct billed to employees, not a payroll deduction.

A little background and important points on this coverage:

- Staff released an RFP for Long Term Care.
- UNUM was the sole responder
- Commissioners Court approved offering the UNUM Long Term Care insurance plan to retirees and actives during the voting session on 9-27-11.
- At that time we planned for the effective date to be March, 1, 2012, but as we went through the process, the **effective date changed to April, 1, 2012** in order to allow the employees a little more time to enroll to take advantage of the guarantee issue period.
- The initial enrollment period was January 4, through February 15, 2012. This was the opportunity for active employees to enroll under guarantee issue, which meant that no medical underwriting was required to enroll. This was the only opportunity for active employees to enroll without medical underwriting. Over 100 enrollment information sessions were held throughout the County.
- Active employees / retirees/ family members can apply for coverage anytime, with medical underwriting. UNUM will approve or deny the application, Not everyone will be approved. Eligible Family members must be between ages 18-80.
- This insurance will not be on Open Enrollment system as it is not an annual benefit election and employees can apply for coverage at any time.
- New hires will be offered Long Term Care under guarantee issue once a year during February.
- This insurance is not a payroll deduction, it will be direct billed by UNUM to home address of the participants. It is portable and does not end if you no longer work at the County or if you retire.
- You pay the rates based on the age at enrollment, and you always will pay the rates based on that age. So rates do not increase as you age.

AGREEMENT
UNUM LIFE INSURANCE COMPANY OF AMERICA
FOR LONG TERM CARE GROUP BENEFITS PROGRAM

This agreement is made by the following parties:
UNUM Life Insurance Company of America, a Maine corporation ("Company") and County of Travis, Texas ("County").

RECITALS

County distributed a Request for Proposals (RFP No. P110080-OJ) (the "RFP") to qualified companies to provide long term care insurance. County enters into contracts with qualified companies to provide employees with the opportunity to purchase long term care insurance as a group employee benefit.

All coverages and services provided under the Agreement and the Insurance Contract are voluntary.

Company has developed certain systems that provide the services sought by County and will be providing the services sought.

AGREEMENT

1.0 DEFINITIONS

In this agreement, and its attachments, words defined in the attachments and used in this agreement have the defined meaning in the attachment and the following words have the meanings shown in this section:

1.01 "Auditor" means the Travis County Auditor or her designee.

1.02 "Policy Year" means the year beginning April 1 and ending the last day of March.

1.03 "Commissioners Court" means Travis County Commissioners Court.

1.04 "County" means County of Travis, a political subdivision of the State of Texas.

1.05 "Historically Underutilized Business" or "HUB" means any entity or association formed to make a profit in which one (1) or more persons who are socially disadvantaged because of their identification as members of one of the following groups: African Americans, Hispanic Americans, Asian Pacific Americans, Native Americans, Women of any ethnicity have the following rights:

1.05.1 own at least fifty-one percent (51%) of all classes of shares or other equitable securities and have incidents of ownership, including an interest in profit and loss, equivalent to the percentage of capital, equipment or expertise contributed to the

business where ownership is measured as though the community property interest of a spouse is the separate property of that spouse, if both spouses certify in writing that the non-participating spouse relinquishes control over his or her spouse, and his or her community property, and not as if it is subject to the community property interest of the other spouse; and

1.05.2 have a proportionate interest and demonstrated active participation in the control, operation and management of the business's affairs; where control means having recognized ultimate control over all day-to-day business decisions affecting the business, which is known to, and at least tacitly acknowledged in day-to-day operations, by employees of the business and by those with whom business is conducted, and holding a title commensurate with that control.

1.06 "Is doing business" and "has done business" mean:

1.06.1 paying or receiving in any calendar year any money or valuable thing which is worth more than $250 in the aggregate in exchange for personal services or for the purchase of any property or property interest, either real or personal, either legal or equitable; or,

1.06.2 loaning or receiving a loan of money; or goods or otherwise creating or having in existence any legal obligation or debt with a value of more than $250 in the aggregate in a calendar year;

1.06.3 but does not include

1.06.3.1 any retail transaction for goods or services sold to a Key Contracting Person at a posted published or marked price available to the general public.

1.06.3.2 any financial services product sold to a Key Contracting Person for personal, family or household purposes in accordance with pricing guidelines applicable to similarly situated individuals with similar risks as determined by Company in the ordinary course of its business; or

1.06.3.3 a transaction for a financial service or insurance coverage made on behalf of Company if Company is a national or multinational corporation by an agent, employee or other representative of Company who does not know and is not in position that he or she should have known about this agreement.

1.07 "Key Contracting Person" means any person or business listed in Exhibit A to the Affidavit attached to this agreement and marked Attachment E-1.

1.08 "Purchasing Agent" means the Travis County Purchasing Agent, acting as agent in administering the agreement, or any County employee designated by her.

1.09 "LTC" means group long term care insurance coverage.

1.10 "Insurance Contract" means the contract of LTC insurance to be issued to County by Company effective April 1, 2012.

1.11 "Covered Person" means any County employee, County retiree or person associated with them who elect long term care insurance coverage and are accepted for coverage by Company.

2.0 TERM OF AGREEMENT

2.01 The initial term of this agreement is the date of approval by Commissioners Court through April 1, 2012, unless terminated by either party in compliance with the applicable Insurance Contract or this agreement. If seven percent (7%) or more of the eligible County employees do not submit applications to enroll for Long Term Care Insurance Coverage before February 15, 2012, that are approved by Company, this agreement shall automatically terminate effective March 31, 2012 and Company is not liable for services to be performed after April 1, 2012.

2.02 If seven percent (7%) or more of the eligible County employees do submit applications to enroll for Long Term Care Insurance Coverage before February 15, 2012, that are approved by Company, this agreement shall automatically renew for four years effective April 1, 2012 and Company is liable for all services to be performed under this agreement, unless this agreement is terminated by either party in compliance with the applicable Insurance Contract or this agreement. The rates outlined in attachment LTC-1 may be extended beyond the forty-eight (48) months commencing April 1, 2012 only upon mutual agreement by County and Company and only if new rates are approved by the State Department of Insurance.

3.0 ENROLLMENT

3.01 County has chosen an initial enrollment period that ends no later than February 14, 2012 and, if the minimum number of applications are received in that enrollment, County may, in its discretion, elect to have a second enrollment period that ends no later than August 31, 2012. The Guarantee Issue opportunity is allowed for all County employees in the initial enrollment. If the minimum number of applications are received in that enrollment and if County elects to have a second enrollment period, the Guarantee Issue opportunity will be allowed for all County employees in the second enrollment period in the first year of the contract. After September 1, 2012, County has chosen an enrollment that takes place once each year and the Guarantee Issue opportunity is only allowed for those newly eligible. Company must accept enrollment information in electronic format through the Company's designated enrollment system. County and Company will coordinate revisions needed to the electronic format if Company changes its designated electronic enrollment system.

3.02 In both the initial term and any renewal terms, Company must provide County with an adequate supply of applications, certificate booklets, and claim forms for all services and coverage for both the annual open enrollment and "new employee" enrollment throughout the year.

Company must send certificates of coverage directly to all Covered Persons. Company will provide adequate and appropriate enrollment materials and resources for annual enrollment. The Company will provide knowledgeable and qualified enrollment staff, Long Term Care information and materials to conduct County's annual enrollment events for up to two days for each annual enrollment during the renewals authorized in 2.1.

4.0 ADMINISTRATION OF AGREEMENT

4.01 During the initial term before April 1, 2012, Company shall perform all services necessary to educate, inform, and assist eligible County employees and retirees in determining whether to submit an application to enroll in Long Term Care Insurance Coverage in a good and professional manner for a similar business in County and render all services promptly and efficiently. Company shall name the person or the team that will manage this account and act as the contact for County.

4.02 Effective April 1, 2012 the Company shall issue a fully insured insurance policy in the form shown in Attachment LTC-1.

4.03 After April 1, 2012, Company shall perform all services necessary to place and manage the agreement, including those described in Attachment LTC-2, and the Insurance Contracts in a good and professional manner for a similar business in County and to render all services promptly and efficiently. Company shall name the person or the team that will manage this account and act as the contact for County.

4.04 Delivery of all products, reports or services under this agreement shall be Free on Board (FOB) to final destination at the address shown below.

Human Resources Management Department
Attn: Benefits Manager
700 Lavaca Street, 4th Floor
Austin, Texas 78701

4.05 No deliveries will be accepted on designated holidays, unless specific prior arrangements have been made. Below is the approved holiday schedule. Future schedules are expected to be similar.

HOLIDAY	2012	
New Year's Day	Monday	Jan 02, 2012
Martin Luther King, Jr. Day	Monday	Jan 16, 2012
President's Day	Monday	Feb 20, 2012
Memorial Day	Monday	May 28, 2012
Independence Day	Wednesday	Jul 04, 2012
Labor Day	Monday	Sep 03, 2012
Veteran's Day	Monday	Nov 12, 2012
Thanksgiving Day	Thursday	Nov 22, 2012
Friday after Thanksgiving	Friday	Nov 23 2012
Christmas Season	Monday	Dec 24, 2012
Christmas Season	Tuesday	Dec 25, 2012

5.0 GENERAL CHANGE OF COVERAGE PROVISIONS

5.01 Company must provide all services and coverage on a fully insured basis.

6.0 LONG TERM CARE

6.01 Effective April 1, 2012 and during the agreement period after that, Company must provide long term care insurance coverage for County's eligible employees and retirees and family members who enroll for this coverage in the manner described in the LTC Insurance Contract; in a timely manner as agreed upon by Company and County; in accordance with the terms and conditions of the Insurance Contracts and this agreement; in compliance with the assurances, certifications, and all other statements made by Company in Attachment LTC-2. For purposes of order of precedence: with respect to eligibility for and the payment of insurance benefits, the terms of the LTC Insurance Contract, including any riders or endorsements, will be the controlling document.

6.02 The rates applicable to the long term care coverage for the first four years of this agreement are stated in the Rate Information Schedule in Attachment LTC-1 unless there are changes in the plan design. After that, the rates applicable to the long term care coverage under this agreement remain the same as during the first four years of this agreement unless there are changes in the plan design or unless Company is increasing the rates on a class basis. Any increase in rates will be approved by the State of Texas and may apply to similar policies, plans, or coverage selections.

7.0 INVOICING AND PAYMENT

7.01 Company shall provide the following administrative services for Covered Persons:

7.01.1 Issue a quarterly invoice directly to the Covered Person's residence or other address identified to Company by the Covered Person and accept quarterly payments of premiums as made directly from the Covered Persons unless a Covered Person elects monthly payments by ACH and maintain accounting records of the payments.

7.01.2 Send an Expiration of Grace Period notice to the Covered Person's address if premiums are 30 days late. If a 3rd party designee is elected by the Covered Person, the third party also receives an Expiration of Grace Period notice.

7.01.3 A Termination Letter will be sent 65 days after the due date of the bill.

7.01.4 There will be an 800 number available to Covered Persons with billing questions.

7.02 The administration of County benefit premiums for long term care coverage for the entire term of this agreement, including all exercised options, shall be included in the premium for the coverage.

7.03 Payment is deemed to have been made on the date of electronic transmission or the date processed through the Company's bank lockbox.

8.0 AUDITING AND MONITORING REQUIREMENTS

8.01 Company shall maintain and make available all books, documents, and other evidence pertinent to the costs and expenses of this agreement for inspection, audit or reproduction by any authorized representative of County to the extent this detail will properly reflect these costs and expenses. These include all costs; both direct and indirect costs, cost of labor, material, equipment, supplies, and services, and all other costs and expenses of whatever nature for which reimbursement is claimed under this agreement. Any such audit conducted by County must be approved in advance by Company's LTC Benefits Center and Company's Privacy Office and conducted in compliance with Company's then current external audit protocols. Any such audit conducted by County shall not include access to books, documents, and other evidence proprietary to Company or which Company may not disclose under applicable law. All required records shall be maintained until an audit is completed and all requested questions arising therefrom are resolved, or three years after completion of the agreement term, whichever occurs first; however, the records will be retained beyond the third year if an audit is in progress or the findings of a completed audit have not been resolved satisfactorily.

8.02 County reserves the right to perform periodic on-site monitoring of Company's compliance with the terms of this agreement, and of the adequacy and timeliness of Company's performance under this agreement. Any such monitoring conducted by County must be approved in advance by Company's LTC Benefits Center and Company's Privacy Office and conducted in compliance with Company's then current external audit protocols. Any such monitoring conducted by County shall not include access to books, documents, and other evidence proprietary to Company or which Company may not disclose under applicable law. After each monitoring visit, County shall provide Company with a written report of the monitor's findings. If the report notes deficiencies in Company's performances under the terms of this agreement, it shall include requirements and deadlines for the correction of those deficiencies by Company. Company shall take action specified in the monitoring report prior to the deadlines specified.

9.0 WARRANTIES AND APPLICABLE INDEMNIFICATIONS

9.01 Company warrants that Company will use its best efforts to provide quality service to County. If County is dissatisfied with the performance of the account representative regularly assigned to work for County, County will notify Company and Company will promptly take corrective action to the parties' mutual satisfaction.

9.02 Company warrants that Company will not engage in employment practices which have the effect of discrimination against employees or prospective employees because of age, religion, race, color, sex, creed, handicap or national origin.

9.03 Company warrants that Company is a duly qualified, capable business entity, that Company is not in receivership and does not contemplate it, and has not filed for bankruptcy

protection and does not contemplate it.

9.04 Company warrants that no persons or selling agency has been retained to solicit this contract upon an understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial selling agencies maintained by the Company to secure business. For breach or violation of this warranty, County shall have the right to terminate this agreement without liability, or in its discretion, as applicable, to add to or deduct from the contract price for consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

9.05. Company warrants that Company is not currently delinquent to County for payment of property taxes.

9.06 Company warrants that all applicable copyrights and licenses which may exist on materials used in this agreement have been adhered to and further warrants that County shall not be liable for any infringement of those rights and any rights granted to County shall apply for the duration of the agreement. Company shall indemnify County, its officers, agents and employees from all claims, losses, damages, causes of action and liability of every kind including expenses of litigation, and court costs and attorney fees for damages to any property arising in connection with any alleged or actual infringement of existing licenses or copyrights applicable to materials used in this agreement. This section shall not be interpreted as a waiver of sovereign immunity and County retains all of its affirmative defenses.

9.07 Company certifies that at the time of submission of its offer, it was not on the Federal Government's list of suspended, ineligible, or debarred contractors and that Company has not been placed on this list between the time of that its offer was submitted and the time of execution of this agreement. If Company is placed on the list during the term of this agreement, Company shall notify the Travis County Purchasing Agent. False certification or failure to notify may result in terminating this agreement for default.

10.0 INDEMNIFICATION

10.01 Company shall indemnify County, its officers, agents, and employees, with respect to any and all claims asserted by any persons for Insurance benefits under County's Policy. Company shall defend and indemnify County with respect to any and all claims, damages liability and court awards including costs, expenses and attorney fees incurred solely as a result of Company's breach of this agreement and from breach of any fiduciary responsibility that Company may have under applicable law. This obligation to defend or indemnify does not extend to claims or causes of action against Company or County based wholly or in part of the acts representations or omissions of County. Company's obligation to defend and indemnify shall apply only to lawsuits in which both the County and Company are named defendants. In discharging this obligation to defend as set forth in this section Company shall allow its counsel to represent interest of County but shall not be obligated to hire or compensate separate counsel on behalf of County.

11.0 LEGAL REQUIREMENTS AND PERMITS

11.01 Company must procure all necessary licenses and permits at its own expense and must conform to all laws, regulations and ordinances applicable to the performance of this agreement.

12.0 CHANGES

12.1 Unless specifically provided otherwise in this agreement, any change to the terms of this agreement shall be made by written change order signed by both parties. The Purchasing Agent may at any time, by written document, make changes within the general scope of this agreement that do not result in premium changes in any one of the following, provided however that any such change must be acceptable to Company and within Company's authority and approvals under applicable laws and regulations:

12.1.1 Description of services;

12.1.2 Place of delivery;

12.1.3 Any aspect of the agreement to correct errors of a general administrative nature or other mistakes, the correction of which does not affect the scope of the agreement and does not result in expense to Company.

12.2 It is acknowledged by Company that no officer, agent, employee or representative of County has any authority to change the scope of this agreement or any attachments to it unless expressly granted that specific authority by the Commissioners Court.

12.3 If any change under 12.1 causes an increase or decrease in the cost, or time required for performance of any part of the work under this agreement, the Commissioners Court shall make an equitable adjustment in the agreement price, the delivery schedule, or both, and modify the agreement. Company must submit any "proposal for adjustment" within 30 days after the date of receipt of the written order.

12.4 Company shall submit all requests for alterations, additions or deletions of the terms of this agreement to the Purchasing Agent. The Purchasing Agent shall present Company's requests to Commissioners Court for consideration.

13.0 DISPUTE RESOLUTION

13.01 When mediation is acceptable to both parties in resolving a dispute arising under this agreement, agree to use a mutually agreed upon mediator, or a person appointed by a court of competent jurisdiction, for mediation as described in section 154.023 of the Texas Civil Practice and Remedies Code. Unless both parties are satisfied with the result of the mediation, the mediation will not constitute a final and binding resolution of the dispute. All communications within the scope of the mediation shall remain confidential as described in section 154.073 of the Texas Civil Practice and Remedies Code, unless both parties agree, in writing, to waive the

confidentiality. Binding arbitration shall be available if agreeable to both parties. Dispute resolution available pursuant to this provision shall not be applicable to any dispute arising out or connected or relating to a claim for benefits under an Insurance Contract.

13.02 The Purchasing Agent acts as the County representative in the issuance and administration of this contract in relation to disputes. Any document, notice, or correspondence not issued by or to the Purchasing Agent, or other authorized County person, in relation to disputes is void unless otherwise stated in this contract. If the Company does not agree with any document, notice, or correspondence issued by the Purchasing Agent, or other authorized County person, the Company must submit a written notice to the Purchasing Agent within ten (10) calendar days after receipt of the document, notice, or correspondence, outlining the exact point of disagreement in detail. If the matter is not resolved to the Company's satisfaction, Company may submit a written Notice of Appeal to the Commissioners Court, through the Purchasing Agent, if the Notice is submitted within ten (10) calendar days after receipt of the unsatisfactory reply. Company then has the right to be heard by Commissioners Court.

14.0 TERMINATION

14.01 Failure to carry out the County HUB Procurement Program in soliciting subcontractors for a service specific to County only is a breach of this agreement and may result in termination of this agreement after written notification to Company of the breach by the Purchasing Agent.

14.02 County may terminate this agreement if it is found that gratuities of any kind including entertainment, or gifts were offered or given by Company or any agent or representative of Company to any County Official or employee with a view toward securing favorable treatment with respect of this agreement. If this agreement is terminated by the County pursuant to this provision, County shall be entitled, in addition to any other rights and remedies, to recover from the Company at least three times the cost incurred by Company in providing the gratuities.

14.03 This agreement shall remain in effect until this agreement expires, or until terminated by County with forty-five (45) days written notice prior to the date of termination.

14.04 Company may terminate or modify this agreement on forty-five (45) days written notice under the following conditions:

14.04.1 If there are fewer than ten (10) employees who pay all or part of their premium for insurance coverage.

14.04.2 County does not provide Company with information that is reasonably required.

14.04.3 County fails to perform any of its obligations that relate to the Insurance Contracts

14.04.4 Company determines that there is a significant change, in the size, occupation, or age of the eligible group as a result of a reorganization of County and/or its employees.

14.05 If this agreement is terminated, Company may only terminate or modify the Insurance Contract related to a particular Covered Person on terms stated in the Insurance Contract. If Company stops offering this type of coverage to new enrollees at any time, Company may not terminate coverage to previously Covered Persons without providing these Covered Persons the option to obtain or maintain their coverage through another provider except that Company may terminate the Insurance contract related to a specific Covered Person for non-payment of premiums by that Covered Person.

14.06 Company may terminate or modify this agreement or the Insurance Contracts on ninety (90) days written notice if required to do so by law.

14.07 County reserves the right to enforce the performance of this agreement in any manner prescribed by law or deemed to be in the best interest of County in the event of breach or default of this agreement. County reserves the right to terminate this agreement immediately if Company fails to perform in accordance with it.

15.0 FORFEITURE OF AGREEMENT

15.01 Company shall forfeit all benefits of the agreement and County shall retain all performance by Company and recover all consideration or the value of all consideration, paid to Company under this agreement if:

15.01.1 Company was doing business at the time of submitting its proposal or had done business during the three hundred and sixty-five (365) day period immediately prior to the date on which its proposal was due with one or more key persons if Company has not disclosed the name of any such key person in its proposal which is expressly incorporated in this agreement; or,

15.01.2 Company does business with a key person after the date on which the proposal that resulted in this agreement due and prior to full performance of the agreement and fails to disclose the name of any such key person in writing to each member of the Commissioners Court and to the County Clerk within ten (10) days after commencing business with that key person.

16.0 WAIVER OF BREACH

16.01 Any waiver by either Company or County of a breach of this agreement is not a continuing waiver of the breach or of a subsequent breach of the same or a different provision. No official, agent, employee or representative of County may waive any breach of any term or condition of this agreement unless expressly granted that specific authority by Commissioner Court.

16.02 Any right in this agreement shall not preclude the exercise of any other right or remedy under this agreement or under any law and any action taken in the exercise of any right or remedy shall not be deemed to be a waiver of any other rights or remedies.

17.0 ASSIGNMENT

17.01 Company shall not assign any part of the services or the coverage provided under this agreement without providing written notice to the Commissioners Court at least thirty (30) days in advance of such assignment. Company may utilize its subcontractors with which it has contracted as of January 1, 2012. In addition, Company may subcontract any service it provides to the extent that the subcontracted service affects policyholders in addition to County. However, Company shall not enter into any subcontracting arrangement for any service specific to County only without the prior written approval or prior written waiver of this right of approval from County. No official, employee, agent or representative of the County may grant the right to assign any part of this agreement without prior specific authority being expressly granted by the Commissioners Court.

17.02 If a change of name is required due to actions initiated by Company, the County Purchasing Agent shall be notified immediately. No change in the obligation of Company or to Company will be recognized until it is approved by Commissioners Court.

17.03 If a subcontract for a service specific to County only is approved, Company shall make a "good faith" effort to take all necessary and reasonable steps to insure HUBs maximum opportunity to be subcontractors under this agreement. Company shall obtain county approval of all proposed HUB subcontractors through the Purchasing Agent.

18.0 ENTIRE AGREEMENT

18.01 All oral and written agreements between the parties to this agreement relating to the subject matter of this agreement that were made prior to the execution of this agreement have been reduced to writing and are contained in this agreement.

18.02 The attachments numbered and named below are made a part of this agreement, and constitute promised performances by Company and County. For matters addressed in the Insurance Contract, the Insurance Contract is controlling. For matters not addressed in the Insurance Contract, if there is any conflict between this documents and the attachments to it, the conflict must be resolved to give effect to the contents of the attachments and to disregard the conflicting portions of this document.

18.03 The Long Term Care Attachments include the following:

Attachment LTC-1	The LTC Draft Insurance Contract and Rate Information Schedule
Attachment LTC-2	Selected Unum Responses to County Questions

18.04 The Ethics Attachment is Attachment E-1, Affidavit and Proposer Certification Form.

19.0 NOTICE

19.01 Any notice required or permitted to be given under this agreement by one party to the other shall be in writing and shall be given and deemed to have been given immediately if delivered in person to the address set forth in this section for the party to whom the notice is given, or on the third day following mailing if placed in the United States Mail, postage prepaid, by registered or certified mail with return receipt requested, addressed to the party at the address hereinafter specified.

19.02 The address of County for all purposes under this agreement shall be:

Cyd Grimes, C.P.M. (or her successor in office)
Purchasing Agent
P.O. Box 1748
Austin, Texas 78767-1748

With copy to (registered or certified mail with return receipt is not required):

Honorable David A. Escamilla (or his successor in office)
Travis County Attorney
P.O. Box 1748
Austin, Texas 78767-1748

19.03 The address of Company for all purposes under this agreement and for all notices hereunder shall be:

Dianne Warner
National Account Manager
5840 Legacy Circle, Suite D-200
Plano, Texas 75024

With copies to:

Unum GLTC Underwriting Department
Attn: William Reid
2211 Congress Street
Portland, Maine 04122

19.04 Each party may change the address for notice to it by giving notice of the change in compliance with 19.0.

20.0 SPECIAL CONDITIONS

20.01 Despite anything else in this agreement, if Company is delinquent in the payment of property taxes to County at any time when it is invoicing for payment, Company hereby assigns

any payment to be made for services and activities provided under this agreement to the Travis County Tax Assessor-Collector for payment of delinquent taxes.

20.02 Company shall not discriminate against any County employee, Company employee or applicant for employment based on race, religion, color, sex, national origin, age or handicapped condition. Company shall provide all services required under this agreement in the same manner that these services would have to be provided to comply with the Civil Rights Act of 1964, as amended, the Rehabilitation Act of 1973, Public Law 93-1122, Section 504, and with the provisions of the Americans With Disabilities Act of 1990, Public Law 101-336 [S.933], Family and Medical Leave Act (FILA), EEOC (Title Seven), and Texas Human Rights Commission Act if Company were an entity bound to comply with these laws.

20.03 In this section "Debt" includes delinquent taxes, fines, fees, and indebtedness arising from written contracts with the County. In accordance with Section 154.045 of the Texas Local Government Code, if notice of Debt has been filed with the County Auditor or County Treasurer evidencing the Debt of Company to the state, the County or a salary fund, a check or warrant may not be drawn on a County fund in favor of the Company, or an agent or assignee of Contractor until the County Treasurer notifies Company in writing that the Debt is outstanding; and the Debt is paid. County may apply any funds County owes Company to the outstanding balance of Debt if the notice made under this subsection includes a statement that the amount owed by the County to Company may be applied to reduce the outstanding Debt.

20.04 Neither party is liable to the other for any delays or damages or any failure to act caused by federal or state laws or the rules, regulations, or orders of any public body or official purporting to exercise authority or control respecting the operations covered by this agreement, or caused by strikes not against the parties, actions of the elements, or acts of God and delays due to the above causes shall not be considered a breach of this agreement.

20.05 Time is of the essence in this agreement.

20.06 Company must comply with all Federal and State laws and regulations, City and County ordinances, orders, and regulations, relating in any way to this agreement.

20.07 Company must secure all permits and licenses, pay all charges and fees, and give all notices necessary for lawful operations.

20.08 Company must pay all taxes and license fees imposed by the Federal and the State Governments and their agencies and political subdivisions upon the property and business of Company.

20.09 If required under Chapter 176 Texas Local Government Code, Company shall file a completed Conflict of Interest Questionnaire in accordance with the requirements of that Chapter and update it in compliance with that Chapter. As between County and Company, Company shall be solely responsible for the preparation of its Conflict of Interest Questionnaire, the accuracy and completeness of the content contained therein and ensuring compliance with all applicable requirements of Chapter 176, Local Government Code.

21.0 CONSTRUCTION OF AGREEMENT

21.01 This agreement is governed by the laws of the United States of America and the State of Texas and all obligations under this agreement shall be performable in County of Travis, Texas.

21.02 If any portion of this agreement is ruled invalid by a court of competent jurisdiction, the remainder of it shall remain valid and binding.

21.03 Words of any gender in this agreement shall be construed to include any other gender and words in either number shall be construed to include the other unless the context in the agreement clearly requires otherwise.

21.04 When any period of time is stated in this contract, the time shall be computed to exclude the first day and include the last day of period. If the last day of any period falls on a Saturday, Sunday, or a day that County of Travis has declared a holiday for its employees, these days shall be omitted from the computation. All hours stated in this agreement are stated in Central Standard Time or Central Daylight Saving Time as applicable in Austin, Texas at that time of year.

21.05 Headings and titles at the beginning of the various provisions of this agreement have been included only to make it easier to locate the subject matter covered by that section or subsection and are not to be used in interpreting this agreement.

UNUM LIFE INSURANCE COMPANY OF AMERICA

By: _____
Printed Name: Donald St. Cyr
Title: Assistant Vice President Long Term Care Underwriting
Its Duly Authorized Agent Date: 3/9/2012

COUNTY OF TRAVIS, TEXAS

By: _____
Samuel T. Biscoe
Travis County Judge

Date: _____

APPROVED AS TO FORM: CONFIRMED: PURCHASING LAWS COMPLIANCE

_____ _____

County Attorney Cyd Grimes, Travis County Purchasing Agent

CONFIRMED: FUNDS AVAILABLE

_____

Susan Spataro, Travis County Auditor

GROUP LONG TERM CARE INSURANCE POLICY

POLICYHOLDER: County of Travis

Attachment LTC-1

POLICY NUMBER: 205655 001

POLICY EFFECTIVE DATE: April 1, 2012

POLICY ANNIVERSARY: April 1, 2013 and each following April 1

GOVERNING JURISDICTION: Texas

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

The Policyholder should read the policy carefully and contact us promptly with any questions.

The policy is delivered in and is governed by the laws of the governing jurisdiction.

QUALIFIED LONG TERM CARE INSURANCE POLICY

The policy is intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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

Secretary

President

Underwritten by:
Unum Life Insurance Company of America
2211 Congress Street, Portland, Maine 04122
(207) 575-2211

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BENEFITS AT A GLANCE
Long Term Care Insurance

This long term care plan pays benefits if you suffer a Chronic Illness.

POLICYHOLDER: County of Travis

POLICYHOLDER'S ORIGINAL PLAN EFFECTIVE DATE: April 1, 2012

POLICY NUMBER: 205655 001

ELIGIBLE GROUP(S):

All Employees, Their Spouses/Domestic Partners, and Their Family Members, Retirees and Their Family Members

Employees must be in Active Employment with the Policyholder.

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For Employees in an Eligible Group on or before April 1, 2012: None

For Employees entering an Eligible Group after April 1, 2012: Each April 1st following 30 days of continuous active employment

For Employees, you must be in continuous Active Employment in an Eligible Group during the specified Waiting Period.

You will be eligible to apply during the annual enrollment period as determined by the Policyholder.

REHIRE:

If your employment ends and you are rehired within 30 days, your prior period of work while in an Eligible Group will apply toward the Waiting Period. All other policy provisions apply.

CREDIT PRIOR SERVICE:

For Employees entering an Eligible Group while continuously employed by the Policyholder, Unum will apply your prior period of work toward the Waiting Period to determine your eligibility date.

LTC FACILITY MONTHLY BENEFIT:

For eligible Employees:

$2,000 - $6,000 per month in $1,000 increments

For eligible Retirees:

$2,000 - $6,000 per month in $1,000 increments

For all other eligible persons:

$2,000 - $6,000 per month in $1,000 increments

BENEFIT DURATION:

Choice A
3 years

Choice B
6 years

Choice C
Lifetime

HOME CARE BENEFIT:

You may choose either Professional Home and Community Care or Total Choice Home Care, but not both.

Professional Home and Community Care

50% of the LTC Facility Monthly Benefit

Total Choice Home Care

50% of the LTC Facility Monthly Benefit

ADDITIONAL BENEFITS:

Each of the following benefit(s) is optional:

Inflation Protection - 5% Simple

ELIMINATION PERIOD:

For LTC Facility or Professional Home and Community Care Benefits: 90 accumulated days during which you were receiving this kind of care. The Elimination Period must be satisfied within a period of 730 consecutive days. Benefits begin the day after the Elimination Period is completed.

For Total Home Care: 90 accumulated days from the date that the chronic illness begins.

WHO PAYS FOR THE COVERAGE:

For eligible Employees:

You pay the cost of your coverage.

For eligible Retirees:

You pay the cost of your coverage.

For all other eligible persons:

You pay the cost of your coverage.

EVIDENCE OF INSURABILITY LIMITS:

For eligible Employees:

Evidence of Insurability will be required if you apply:
- for a Lifetime Benefit Duration; or
- more than 31 days after you were eligible for coverage.

After the initial enrollment period, you can apply for coverage with evidence of insurability by filling out the benefit election form and the Long Term Care Insurance Application. These forms can be obtained from the Policyholder.

For all other eligible persons:

You must always submit a Long Term Care Application and provide, at your own expense, Evidence of Insurability satisfactory to us.

WAIVER OF PREMIUM:

No premium payments are required for your coverage while you are receiving monthly benefit payments under this policy.

ADDITIONAL CARE BENEFIT:

Once you are eligible for a benefit payment, you will have access to Additional Care Benefits designed to assist you in living at home or in other residential housing, other than a LTC Facility. You do not need to complete the Elimination Period for an Additional Care Benefit payment to begin.

THE ADDITIONAL CARE LIFETIME MAXIMUM BENEFIT AMOUNT: $5,000. This is in addition to your Lifetime Maximum Benefit.

OTHER FEATURES:

Bed Reservation
Respite Care
Contingent Non-Forfeiture
Continuation of Coverage

This is not intended to be a complete description of the Long Term Care policy. This policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage, refer to your Certificate of Coverage.

POLICYHOLDER PROVISIONS

GENERAL INFORMATION

The entire policy for the Policyholder consists of:
- all provisions and any amendments, riders and/or attachments issued;
- the Policyholder's signed application; and
- the Certificate of Coverage.

This policy is issued in consideration of the application and the remittance of the premium. It is subject to the terms and conditions stated.

This policy may not be changed unilaterally. Only an officer or a registrar of Unum and the Policyholder can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy. Any changes to this policy must be offered to each person insured under this policy at the time the change is made. The insured may accept or decline the offer.

PREMIUM RATES

The initial premium for each plan is based on the initial rates shown in the Rate Information Schedule. We may change the premium rates when the terms of this policy change or as otherwise allowed under the Guaranteed Renewable provision. The Policyholder will be notified in writing at least 60 days in advance of any premium rate increase.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Schedule.

PREMIUM DUE DATES AND PAYMENTS

Premium Due Dates are shown in the Rate Information Schedule.

The first Premium Due Date will be the Policy Effective Date. All premiums due, including any adjustments must be paid on or before the applicable Premium Due Date. Premiums must be sent to us at 2211 Congress Street, Portland, Maine 04122, or at the address designated on the bill for that purpose. Premiums are payable in U.S. currency only.

PREMIUM INCREASES AND DECREASES

Premium increases or decreases that take effect during a policy month are adjusted and due on the next Premium Due Date following the change.

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

GRACE PERIOD

The Grace Period for the policy is the 31 consecutive days that begin with the day a premium is due. The policy will remain in effect and coverage will continue during that time.

If Unum, at its sole discretion, agrees to waive the Grace Period in any instance, such agreement will not preclude or prejudice enforcement of the Grace Period in any other instance.

POLICYHOLDER AND UNUM OBLIGATIONS

The Policyholder must provide the following information to Unum on a regular basis:
- information about Employees:

- who become eligible to be insured;
- who become ineligible for coverage;
- occupational information and any other information that may be required to manage a claim; and
- any other information within its possession that may be reasonably required.

Policyholder records that, in our opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

If the information provided is inaccurate, we will:
- use the corrected, factual information to decide whether the person can receive coverage; and
- make a fair adjustment of premium.

Clerical error or omission by us will not:
- prevent a person who is otherwise entitled to coverage or benefits from receiving such coverage or benefits;
- entitle a person to receive coverage or benefits if that person is not otherwise entitled to receive coverage or benefits;
- affect the amount of a person's coverage; or
- cause a person's coverage to begin or continue when the coverage would not otherwise be effective.

CHANGES IN THE POLICY

We reserve the right to change this policy when, in our sole discretion and subject to prior approval by the state insurance department, we deem such change necessary to:
- comply with federal or state laws or regulations applicable to this policy; or
- maintain this policy as a qualified long term care contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

Written notice of any such change will be provided as soon as reasonably possible to the Policyholder and, when appropriate, to certificate holders under this policy. The Policyholder may terminate this policy or a plan if the modifications are unacceptable.

POLICY TERMINATION

This policy or a plan under this policy can be terminated:
- by Unum; or
- by the Policyholder.

We may terminate this policy, by written notice of at least 45 days, if:
- the number of Employees covered under this policy falls below 10; or
- the Policyholder does not promptly report to Unum the names of any Employees who are added or deleted from the Eligible Group; or
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the Employee, or both, pay the premiums; 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 Policyholder and/or its Employees.

We may terminate this policy if required to do so by law. In this event, we will give the Policyholder at least 90 days written notice prior to the date this policy is to be terminated. This policy will be considered terminated as of the last day of the calendar month following the 90 day written notice of termination.

The Policyholder can terminate this policy at any time if it delivers written notice to us at least 45 days before the termination date. In this event, this policy will be considered terminated as of the last day of the calendar month coincident with or next following the end of the 45 day notice period.

Termination of this policy will be without prejudice to any benefits payable to a person insured under this policy and any attached riders if eligibility for such benefits or Chronic Illness began while that person's Long Term Care insurance was in force, and continues without interruption after termination. Such extension of benefits will be limited to the duration of the payment of that person's Lifetime Maximum Benefit.

If this policy is terminated, all insured persons will have a guaranteed right to elect to continue coverage subject to the **CONTINUATION OF COVERAGE** provision.

REFUND OF PREMIUM DUE TO TERMINATION OF THE POLICY

In the event the policy is terminated by us, we will, within 30 days of the effective date of such termination, refund the premium paid for any period beyond the end of the month following the date the policy is terminated.

FAMILY MEDICAL LEAVE

Once an Employee's coverage has become effective, if that Employee is on family or medical leave of absence, we will continue the Employee's coverage under this policy in accordance with the Policyholder's human resource policy on family and medical leaves of absence. Coverage will continue if the following conditions are met:
- premiums for the Employee are paid in accordance with policy provisions; and
- the Policyholder has approved the Employee's leave of absence in writing.

Coverage will be continued for up to the greater of:
- the leave of absence period required by the federal Family and Medical Leave Act of 1993, and any amendments;
- the leave of absence period required by applicable state law; or
- the leave of absence period provided by the Policyholder's human resource policy for Employees' medical leaves for sickness or injury.

NON PARTICIPATING - DIVIDENDS NOT PAYABLE

This policy does not participate in Unum's profits or surplus earnings. No dividends will be paid at any time.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

None

RESERVE TRANSFER

In the event the Policyholder terminates it's Group Long Term Care Insurance Policy with Unum and there are more than 250 in force Employee Certificates, Unum will transfer net benefit reserves for those individuals who elect coverage under another carrier's equivalent long term care program sponsored by the Policyholder that charges premiums based on the insured's age at enrollment in Unum's Policy. In order for Unum to transfer reserves, the following conditions must be satisfied, unless otherwise agreed upon at the time of transfer:

- The Policyholder must provide Unum Life Insurance Company of America with a current eligibility file, in electronic format, that lists each active employee insured under the Policy.
- The replacement carrier must assume responsibility for communicating its long term care plan and enrolling all current insureds that elect to transfer to the replacement carrier's plan.
- Communication material used by the replacement carrier and the Policyholder must offer every current insured the option of exercising Unum's Continuation of Coverage policy feature.
- Communication material used by the replacement carrier must comply with applicable regulations, and Unum must approve all material sent to current insureds for regulatory compliance and accuracy regarding Unum's Policy, its terms and conditions.
- Unum will not transfer reserves for insureds who have elected to continue coverage under Unum's Group Long Term Care Policy.
- Unum will not transfer reserves for insureds who are currently receiving benefits under the Policy.
- Unum will not transfer reserves for insureds who have not affirmatively elected to transfer coverage to the replacement carrier.

The amount of reserves transferred shall be summed over all insureds who have affirmatively elected to transfer coverage to the replacement carrier. Unum will transfer the net benefit reserve ("GAAP active life reserve"), held on those individuals electing to transfer coverage to a replacement carrier, less unamortized acquisition expenses allocated to those electing to transfer to the replacement carrier.

The net benefit reserve and unamortized acquisition expenses will be calculated using Unum's actuarial assumptions, plan design and benefits at the time of original issue of coverage. For incremental plan and benefit changes, the net benefit reserve and unamortized acquisition expenses will be based upon the actuarial assumptions in effect at that time.

There will be no expense charge for the standard transfer of data and reserves from Unum to the replacement carrier, however if special requests are made for data and information, the actual cost incurred to satisfy the special request will be deducted from the reserve amount otherwise transferred.

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

CERTIFICATE OF COVERAGE

This Certificate of Coverage is part of the entire policy. This Certificate is subject to the terms and conditions stated on the attached pages, all of which terms and conditions are part of the policy. The policy determines governing contractual provisions and is available for viewing at the Policyholder's office and will be copied for you upon request at no cost. This Certificate is evidence of your coverage under the policy. It describes the benefits, coverage, exclusions and limitations of the policy that principally affect you. This Certificate is of value to you. Please keep it in a safe place.

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

IMPORTANT CAUTION ABOUT YOUR APPLICATION

If you were required to complete a Long Term Care Insurance Application in connection with your request to obtain coverage, the issuance of this Certificate is based upon medical and other questions you answered in your application. A copy of your Long Term Care Insurance Application was retained by you when you applied. If for any reason any of your answers are incorrect or untrue, contact us immediately at the address stated below to the attention of the Long Term Care Division. If your answers are incorrect or untrue, we may deny benefits or void your coverage. The best time to clear up any questions is now, before a claim arises.

NOTICE TO BUYER

This Certificate may not cover all the costs associated with long term care incurred by you during the period of coverage. You are advised to review carefully all policy limitations. In addition, you are advised that based on current health care cost trends, the benefits provided by your Certificate may be significantly diminished in terms of real value to you, depending on the amount of time which elapses between the date of purchase and the date upon which you first become eligible for those benefits.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Guide to Health Insurance For People with Medicare available from us.

We are not representing Medicare, the federal government or any state government.

30 DAY RIGHT TO EXAMINE YOUR CERTIFICATE

You may cancel this Certificate for any reason within 30 days after it is delivered to you or your representative. Simply return this Certificate, within 30 days of its receipt, to the Policyholder's plan administrator or Unum. If this is done, this Certificate will be canceled from the beginning, and all of the premium paid will be refunded.

GUARANTEED RENEWABLE

Your coverage is Guaranteed Renewable up to the Lifetime Maximum Benefit Amount shown on your **Schedule of Benefits**. We have a limited right to change premium. This means that you have the right to continue your long term care insurance coverage in force as long as premium for your coverage is paid when it is due. If your coverage terminates for any reason other than for non-payment of premium, you will have a guaranteed right to continue your coverage subject to the **CONTINUATION OF COVERAGE** provision.

However, we reserve the right to change any or all premiums. Any change in premium must apply to all similar policies issued, on this policy form, in the state in which the policy is situsued. Premiums cannot be increased because of any change in the age or health of the persons covered under the policy. Written notice will be provided to the Policyholder at least 60 days in advance of any increase in premiums.

We cannot discontinue the policy except where required by law or as a result of nonpayment of premium or other causes as described in the Policy Termination section of the policy.

EFFECTIVE DATE

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

Secretary

President

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unum's toll-free telephone number for information or to make a complaint at:

1-800-321-3889

You may call Unum's toll-free telephone number for information at:

1-800-331-1538

You may also write to Unum at:

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

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may also write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance (TDI).

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Unum's para informacion o para someter una queja al:

1-800-321-3889

Usted puede llamar al numero de telefono gratis de Unum's para informacion al:

1-800-331-1538

Usted tambien puede escribir a Unum:

Deborah J. Jewett
Gerente de Relaciones al
Cliente
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

WORDS THAT HAVE A SPECIAL MEANING

"Active Employment" means you are working for the Policyholder:
- on a full-time basis for earnings that are paid regularly; and
- are performing the material and substantial duties of your regular occupation; and
- are working at least the minimum number of hours as described under Eligible Group(s) in **Benefits at a Glance** for each plan.

Your work site must be:
- the Policyholder's usual place of business;
- an alternative work site at the direction of the Policyholder, 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.

"Activities of Daily Living" (ADLs) are:
- Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs.
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring: having the ability to move into or out of a bed, chair or wheelchair, or to move from one location to another, indoors and outdoors, either via walking, a wheelchair, or other means.
- Continence: the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube, or intravenously.

You will be considered able to perform the above Activities of Daily Living if you do not require the Substantial Assistance of another person to perform the ADLs.

"Adult Day Care" means a social and health-related services program provided during the day in a community group setting for the purpose of supporting the frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

We will not recognize a Family Member as an Adult Day Care provider for claims that you make to us under this Policy, unless the Family Member is a regular employee of the Adult Day Care Facility or Total Choice Home Care is shown in your **Schedule of Benefits.**

"Adult Day Care Facility" means a provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality care requirements in the provision of Adult Day Care).

"Certificate" means this Certificate and any riders attached to this Certificate.

"Chronic Illness" and "Chronically Ill" mean:
- you are unable to perform, without Substantial Assistance from another individual, two (2) or more Activities of Daily Living; or
- you require Substantial Supervision by another individual to protect you from threats to your health and safety due to Severe Cognitive Impairment.

"Coverage Effective Date" means the date your coverage begins. Your Coverage Effective Date is shown on your **Schedule of Benefits**.

"Eligible Family Member" means a person ages 18 through 80 who is in a class of persons eligible for coverage as determined by the Policyholder and us and is residing in the United States, its territories or possessions and who is:

- the legally married spouse of an Employee or Retiree.
- the natural, adoptive or step parents of an Employee or spouse.
- the natural, adoptive or step grandparents of an Employee or spouse.
- the natural, adoptive or step siblings of an Employee or spouse.
- the spouse of the Employee's natural, adoptive or step siblings.
- the spouse of the Employee's spouse's natural, adoptive or step siblings.
- the natural, adoptive or step adult children of an Employee.
- the spouse of a natural, adoptive or step adult child of an Employee.
- the domestic partner of an Employee or Retiree. A domestic partner is the person named in the Employee's or Retiree's declaration of domestic partnership. The declaration must be executed and provided to the plan administer which gives proof that the domestic partner has had the same permanent residence as the Employee or Retiree for a minimum of 6 consecutive months prior to the date insurance would become effective for that domestic partner. The Employee or Retiree must not have signed a declaration of domestic partnership with anyone else within the last 6 months of signing the latest declaration. Also the domestic partner must be least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named domestic partner, and not married to anyone else. The declaration of domestic partnership must be approved and recorded by the plan administrator.

If a person could be eligible both as a Family Member and as an Employee or Retiree, the person is deemed to be only eligible for coverage as an Employee or Retiree.

"Elimination Period"
If LTC Facility only is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services must be provided in a LTC Facility.

If LTC Facility with Professional Home and Community Care is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services must be provided in a LTC Facility; or by/through a Licensed Home Health Care Agency; in an Adult Day Care Facility; or by a Licensed Home Health Care Professional.

Each calendar week during which you receive at least one (1) day of Professional Home and Community Care Services will be counted as seven (7) days towards the completion of your Elimination Period.

If LTC Facility with Total Choice Home Care is shown in your **Schedule of Benefits**:
"Elimination Period" means the number of days during which you are Chronically Ill and you are receiving services appropriate for your Chronic Illness, but no benefit is payable. The care or services may be provided to you by anyone including a Family Member; or in a LTC Facility; or by/through a Licensed Home Health Care Agency; by a Licensed Home Health Care Professional; in an Adult Day Care Facility or by an informal caregiver.

Once you are Chronically Ill, your Elimination Period must be completed within a period of 730 days. You must satisfy your Elimination Period only once during the lifetime of the policy. The number of days in your Elimination Period is shown in your **Schedule of Benefits.**

"Employee" means a person who is employed by the Policyholder and who is in a class of persons eligible for coverage as determined by the Policyholder and is residing in the United States, its territories or possessions.

"Family Member" means you, your spouse, or domestic partner, or persons related to you, your spouse or domestic partner, including adopted, in-law and step relatives, such as a parent, grandparent, child, grandchild, brother, or sister.

"Grace Period" means the 31 days immediately following any Premium Due Date during which premium payment must be made.

"Home Care Monthly Benefit" means the selected Professional Home and Community Care or Total Choice Home Care Monthly Benefit as shown in your **Schedule of Benefits**.

"Home Health Care Services" means medical or nonmedical services provided to Chronically Ill or infirm persons in their residences. Such services may include Homemaker Services, assistance with Activities of Daily Living, Respite Care, case management services, and maintenance or personal care services provided by a home health aide.

"Homemaker Services" means assistance with activities necessary to or consistent with your ability to remain living in your residence. Homemaker Services may be provided by skilled or unskilled persons but must be provided through a Licensed Home Health Care Agency or by a Licensed Home Health Care Professional. A Family Member cannot provide Homemaker Services, unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Total Choice Home Care is shown in your **Schedule of Benefits**.

"Licensed Health Care Practitioner" means any Physician, a registered professional nurse, a licensed social worker, or any other individual who meets such requirements as may be prescribed by the Secretary of Treasury.

We will consider a person to be a Licensed Health Care Practitioner only when the person is performing tasks that are within the limits of the person's license, and such tasks are appropriate to the care of your Chronic Illness. We will not recognize a Family Member as a Licensed Health Care Practitioner for claims that you make to us under the policy.

"Licensed Health Care Practitioner's Certification" means a written certification provided by a Licensed Health Care Practitioner that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

"Licensed Home Health Care Agency" means a business that provides Home Health Care Services and is licensed by the Texas Health and Human Services Commission.

We will not recognize a Family Member as a Licensed Home Health Care Agency provider for claims that you make to us under this Policy, unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Adult Day Care Facility or Total Choice Home Care is shown in your **Schedule of Benefits**.

"Licensed Home Health Care Professional" means a licensed therapist, a registered nurse, a licensed practical nurse, a licensed vocational nurse or a certified hospice caregiver operating within the scope of his or her license and/or certification. A Licensed Home Health Care Professional must provide services pursuant to a written Plan of Care and maintain patient records.

We will not recognize a Family Member as a Licensed Home Care Professional for claims that you make to us under the policy, unless Total Choice Home Care is shown in your **Schedule of Benefits**.

"Lifetime Maximum Benefit" means the total dollar amount of benefits that will be paid under the policy, as shown in your **Schedule of Benefits**, excluding any Additional Care Benefit. Your Lifetime Maximum Benefit will be adjusted to include any Inflation Protection increases, if applicable.

"Long Term Care Facility" (LTC Facility) means a facility (such as a nursing facility, an assisted living facility, a hospice facility, a rehabilitation facility, an Alzheimer's facility or a residential care facility) that is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support your needs resulting from a Chronic Illness.

If licensing is not required, a LTC Facility must:
- provide care 24 hours a day;
- provide three (3) meals a day, including special dietary requirements;
- have an employee on duty at all times who is awake, trained and ready to provide care;
- have formal arrangements for services of a Physician or nurse in the event of a medical emergency;
- be authorized to administer medication to patients on the order of a Physician; and
- have accommodations for at least three (3) inpatients in one location; or
- be a facility that provides a formal program of care for terminally ill patients whose life expectancy is less than six (6) months, provided on an inpatient basis and directed by a Physician, such as a hospice facility; or
- be Medicare certified; or
- be a similar facility approved by us.

NOTE: If a facility has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a LTC Facility only if it:
- meets all of the above criteria;
- is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and
- is primarily engaged in providing not only room and board, but also care and services, which meet all of the above criteria.

A LTC Facility is NOT:
- a hospital or clinic;
- a sub-acute hospital or unit;
- a place which operates primarily for the treatment of alcoholism or drug addiction;
- the insured person's primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or
- a substantially similar establishment.

"LTC Facility Monthly Benefit" means the LTC Facility Monthly Benefit amount shown in your **Schedule of Benefits**.

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the state in which he or she performs such function or action.

We will consider a person to be a Physician only when the person is performing tasks that are within the limits of the person's medical license, and such tasks are appropriate to the care of your Chronic Illness. We will not recognize a Family Member as a Physician for claims that you make to us under the policy.

"Plan of Care" means a written plan prescribed by a Licensed Heath Care Practitioner, based upon an assessment that evaluates your level of functional capacity. The Plan of Care must describe the necessary services to be performed, the frequency, the type of care, and the most appropriate providers for such care. The care described must be in accordance with acceptable medical and nursing standards of practice and must be appropriate for your Chronic Illness.

"Policyholder" means the entity to which the policy is issued.

"Policy Effective Date" means the date the policy begins. The Policy Effective Date is shown on the face page of the policy.

"Professional Home and Community Care Monthly Benefit" means the Professional Home and Community Care Monthly Benefit amount shown in your **Schedule of Benefits**.

"Professional Home and Community Care Services" means Qualified Long Term Care Services provided to you for at least one (1) hour or more per day by/through a Licensed Home Health Care Agency, by a Licensed Home Health Care Professional, or in an Adult Day Care Facility.

Professional Home and Community Care Services include:
- nursing care;
- physical, respiratory, occupational or speech therapy;
- Homemaker Services;
- hospice care; or
- other services pursuant to your Plan of Care.

Professional Home and Community Care Services does not include:
- care or services provided by a Family Member directly or through a Licensed Home Health Care Agency, an Adult Day Care Facility or by a Licensed Home Health Care Professional unless the Family Member is a regular employee of the Licensed Home Health Care Agency or Adult Day Care Facility; or
- care or services provided by a Family Member who is a Licensed Home Health Care Professional; or
- care in LTC Facility or in an acute care hospital or other location excluded by the policy.

"Qualified Long Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services that are required by you. The services must be for your Chronic Illness and provided pursuant to a written Plan of Care; and you must obtain a Licensed Health Care Practitioner's Certification. You must be receiving Qualified Long Term Care Services in a Long Term Care (LTC) Facility or, if selected, receiving a Home Care Monthly Benefit.

"Respite Care" means short-term or periodic Qualified Long Term Care Services which are required to maintain your health or safety and to give temporary relief to your primary informal caregiver from his or her caregiving duties.

"Retiree" means a person who is a retired Employee of the Policyholder who is in a class of persons eligible for coverage as determined by the Policyholder and us.

"Severe Cognitive Impairment" means a severe deterioration or loss in your short or long term memory; your orientation as to person, place, or time; or your deductive or abstract reasoning as reliably measured by clinical evidence and standardized tests. Such loss can result from a sickness, injury, advanced age, Alzheimer's disease, or similar form of dementia.

"Substantial Assistance" means stand-by or hands-on assistance without which you would not be able to safely and completely perform the ADL. Stand-by assistance means the presence of another person within arm's reach of you while you are performing the ADL. Hands-on assistance means physical assistance (minimal, moderate, or maximal) without which you would not be able to perform the ADL.

"Substantial Supervision" means continual supervision (which may include cueing by verbal prompting, gestures or other demonstrations) by another individual for the purpose of protecting you from threats to your health or safety.

"Temporary 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 the Policyholder.

Your normal vacation time or any period of Chronic Illness is not considered a Temporary Layoff or Leave of Absence.

"Total Choice Home Care Monthly Benefit" means the Total Choice Home Care Monthly Benefit amount shown in your **Schedule of Benefits**.

"Total Choice Home Care Services" means Qualified Long Term Care Services provided to you by anyone including a Family Member, by/through a Licensed Home Health Care Agency, by a Licensed Home Health Care Professional, in an Adult Day Care Facility or by an informal caregiver.

Total Choice Home Care Services include:
- nursing care;
- physical, respiratory, occupation or speech therapy;
- Homemaker Services;
- hospice care; or
- other services pursuant to your Plan of Care.

Total Choice Home Care Services does not include:
- care in a LTC Facility;
- care in an acute care hospital; or
- care in other locations excluded by this policy.

The terms "you" and "your" refer to the insured named in your **Schedule of Benefits**. The insured cannot be changed.

"Unum", "we", "us", and "our" mean Unum Life Insurance Company of America.

THE CERTIFICATE OF COVERAGE

This Certificate is a written statement prepared by Unum and may include attachments. It tells you:
- the coverage to which you may be entitled;
- to whom Unum will make a payment;
- the limitations, exclusions and requirements that apply within a plan.

ELIGIBILITY FOR COVERAGE

Employee

If you are working for the Policyholder in an Eligible Group, the date you are eligible for coverage is the later of:
- the Policy Effective Date; or
- the day after you complete your Waiting Period.

Eligible Family Members

If you are an Eligible Family Member, you will be eligible to apply for coverage on the later of:
- the Policy Effective Date; or
- the date the Employee is eligible to apply for coverage.

Retiree

If you are a Retiree of the Policyholder, you will be eligible to apply for coverage any time on or after the Policy Effective Date.

Although you may be eligible for coverage, your coverage will not begin until the date shown on your **Schedule of Benefits**, subject to the timely payment of premium for your coverage.

APPLICATION AND ENROLLMENT FOR COVERAGE

Employee

During your initial enrollment period, you can enroll for coverage without completing a Long Term Care Insurance Application for amounts that do not exceed the Evidence of Insurability limits as shown in the **Benefits at a Glance**. Simply complete a benefit election form. You can obtain a benefit election form from the Policyholder's plan administrator.

If the Policyholder pays the full amount of premium for your coverage, you do not need to enroll for coverage. However, you may need to enroll for coverage, by completing a benefit election form, when you pay all or a portion of the premium.

If you enroll for coverage after your initial enrollment period, you may be required to complete a Long Term Care Insurance Application in addition to the benefit election form.

Retiree, Eligible Family Members

You can apply for coverage with Evidence of Insurability at any time after the date you become eligible for coverage by completing the benefit election form and the Long Term Care Insurance Application. These forms can be obtained from the Policyholder or Unum.

COVERAGE EFFECTIVE DATE

Your coverage will begin at 12:01 a.m. on the latest of:
- the date you are eligible for coverage if we have received your benefit election form, and you applied for coverage on or before that date;

- the date you are eligible for coverage if we have received your benefit election form, and you applied for coverage within 31 days after your eligibility;
- the date Unum approves your Long Term Care Insurance application if Evidence of Insurability is required.

Your Coverage Effective Date will be the date shown in your **Schedule of Benefits** subject to the timely payment of premium for your coverage.

WHEN COVERAGE WILL BE DELAYED FOR EMPLOYEES

For Employees, if you are absent from work due to injury, sickness, Temporary Layoff or Leave of Absence on your Coverage Effective Date, coverage will not begin until you return to work in Active Employment and we receive premium for your coverage.

TEMPORARY ABSENCE FROM WORK ONCE COVERAGE HAS BEGUN FOR EMPLOYEES

For Employees, 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.

For Employees, 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.

INCREASES IN COVERAGE

After your coverage is in force, you can apply to increase coverage, based on the benefits available as shown in the **Benefits at a Glance**, by sending us a new benefit election form and a Long Term Care Insurance Application.

No increased or additional coverage will become effective unless we approve your Long Term Care Insurance Application for such change. If we approve your changes in coverage, you must pay the new premium due. You will be notified of the new premium due amount and the date it is due.

You may apply for increases in coverage annually. Premiums currently charged may be adjusted due to changes or increases in coverage. Upon approval, the change(s) you requested will replace existing benefit option(s) or your benefit duration.

DECREASES IN COVERAGE

You have the right to reduce your coverage and lower your premium, based on the benefits available as shown in the **Benefits at a Glance**, in at least one of the following ways:
(a) reducing your maximum benefit amount; or
(b) reducing your monthly benefit amount.

You can decrease your coverage at any time by sending us a new benefit election form. Premium currently charged may be adjusted due to changes or decreases in coverage. Your **Schedule of Benefits** will reflect your new premium amount and the date it is due.

TERMINATION OF BENEFITS

Your benefit payments under the policy will end on the earliest of:
- the day after you are no longer Chronically Ill;
- the day after the expiration of your Licensed Health Care Practitioner's Certification;
- the day after you are no longer receiving Qualified Long Term Care Services;
- the day after your Lifetime Maximum Benefit has been reached;
- the day after you die.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest of:
- the day after your Lifetime Maximum Benefit has been reached;
- the day after the end of your Grace Period, if premiums for your coverage are not paid within the Grace Period, subject to the notification of lapse;
- the day after we receive your written notification that you wish to cancel your coverage; or
- the day after you die.

Your coverage will also terminate on the earliest of the following events:
- the date the group policy terminates; or
- the date you are no longer in an Eligible Group with the Policyholder; or
- the day after the pay period ends for which premiums were last paid to us by the Policyholder for your coverage;

unless you elect to continue your coverage under the Continuation of Coverage provision.

CONTINUATION OF COVERAGE

If you are no longer eligible for coverage as an Employee or Retiree your continued coverage will remain in force under the existing group policy. If the existing group policy terminates, your coverage may be continued subject to the terms of this certificate. Your continued coverage will remain in force as long as you continue timely payment of premium when due. You must pay premium directly to Unum for your continued coverage.

If you did not apply for coverage during the time you were otherwise eligible to apply for coverage, or if you were not approved for coverage during the time you were otherwise eligible for coverage, you are not eligible to apply for Continuation of Coverage.

You may not elect to continue coverage if you are not insured under the group policy on the date the group policy terminates.

The premium rate schedule for continued coverage may change in the future, depending on:
- the overall use of the benefits by all insured persons; or
- changes in the benefit levels or other risk factors.

Any such change will be made for all insureds in the same class.

You may make changes to your continued coverage at any time. Changes must be based on the current Benefit Options available under the group policy from which you terminated. To change your coverage, you must contact Unum's home office for assistance. You will need to complete the necessary forms which may include a Long Term Care Insurance Application.

STATEMENTS

We consider any statements you make for insurance in any signed application for coverage to be complete and true to the best of your knowledge and belief. In the absence of fraud, all statements made in any application are considered representations and not warranties (absolute guarantees). If any of these statements are not complete and/or not true at the time they were made, we can, in accordance with the **INCONTESTABILITY** provision:
- reduce or deny any claim; or
- terminate your coverage from the original effective date.

No such statements made by you will be used to deny a claim unless a copy of your statements has been given to you.

INCONTESTABILITY

If your coverage has been in force for less than two (2) years, we may rescind your coverage or deny any otherwise valid long term care insurance claim upon a showing of misrepresentation and intent to deceive in your application for insurance.

After two (2) years from the date of issue of your coverage, no misstatements, except fraudulent misstatements made by you in your application for such coverage shall be used to void your coverage or to deny a claim for loss incurred or Chronic Illness commencing after the expiration of such two-year period.

If we have paid benefits under the policy, the benefit payments may not be recovered by us in the event that the coverage is rescinded unless the rescission is due to your fraudulent misstatements.

WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE

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

AGENT

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

BENEFIT PROVISIONS

ELIGIBILITY FOR BENEFITS

You will be eligible for a benefit if, on or after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill.

LIMITATIONS AND CONDITIONS FOR PAYMENT OF BENEFITS

To receive benefits under the policy, the following conditions must be met:
- you must satisfy the Elimination Period, if applicable;
- you must be receiving Qualified Long Term Care Services;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You must also provide us a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

You will be required to submit a Licensed Health Care Practitioner's Certification every 12 months.

A benefit will become payable once all these requirements are met.

LIMITATIONS ON PAYMENT OF BENEFITS

We will not pay benefits in excess of the coverage you chose as shown in your **Schedule of Benefits**. Benefits paid will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached. We will not pay benefits for Qualified Long Term Care Services you receive during the Elimination Period, except as described in the Respite Care Benefit and the Additional Care Benefit provisions. The policy only pays benefits if you are receiving Qualified Long Term Care Services.

BENEFIT PAYMENT

If you are eligible for a LTC Facility Monthly Benefit:

You must give us proof that you are receiving Qualified Long Term Care Services in a LTC Facility before a LTC Facility Monthly Benefit will be paid. If you are eligible for benefits for a period of less than one (1) month, we will pay you 1/30th of the LTC Facility Monthly Benefit for each day that you are Chronically Ill and receiving Qualified Long Term Care Services in a LTC Facility.

The amount of your LTC Facility Monthly Benefit is shown in your **Schedule of Benefits**.

If you selected, and you are eligible for, a Professional Home and Community Care Monthly Benefit:

We will pay 1/30th of the Professional Home and Community Care Monthly Benefit shown in your **Schedule of Benefits** for each day you are receiving Professional Home and Community Care Services. Professional Home and Community Care Services you receive may be provided anywhere other than a LTC Facility, acute care facility or other location excluded by the policy.

You must give us written proof indicating days of Professional Home and Community Care Services provided to you before a benefit will be paid. We will also require a copy of the Licensed Home Health Care Agency's state license, if applicable or the Licensed Home Health Care Professional's state license to practice in his/her respective field prior to payment of benefits.

If you selected, and you are eligible for, a Total Choice Home Care Monthly Benefit:

If you receive Total Choice Home Care Services during the entire month, we will pay the Total Choice Home Care benefit as shown in your **Schedule of Benefits**.

If you receive Total Choice Home Care services for less than one entire month, we will pay 1/30th of the Total Choice Home Care Monthly Benefit shown in your **Schedule of Benefits** for each day after the first day on which you are receiving Total Choice Home Care Services or until the last day on which you are receiving Total Choice Home Care Services. Total Choice Home Care Services you receive may be provided anywhere other than a LTC Facility, acute care facility or other location excluded by the policy.

BED RESERVATION BENEFIT

If you are receiving a LTC Facility Monthly Benefit and your stay in the LTC Facility is interrupted due to a stay in an acute care facility, or due to a temporary absence, and a charge is made to reserve your LTC Facility accommodations, you will be eligible for a Bed Reservation Benefit. We will pay you 1/30th of the LTC Facility Monthly Benefit for each day you are absent from the LTC Facility:
- up to 90 days per calendar year if your absence is due to a stay in an acute care facility; or
- up to 30 days per calendar year for a temporary absence not related to a stay in an acute care facility.

In no event will the total number of Bed Reservation days exceed 90 days per calendar year. Bed Reservation payments will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached.

If your stay in a LTC Facility is interrupted while you are satisfying your Elimination Period, such days will be used to help satisfy your Elimination Period.

RESPITE CARE BENEFIT

If you are Chronically Ill and receiving Respite Care, but you are not receiving a LTC Facility Monthly Benefit or a Home Care Monthly Benefit, if your coverage includes home care, you will be eligible to receive Respite Care. The Respite Care Benefit you will receive is equal to 1/30th of your LTC Facility Monthly Benefit for each day you have Respite Care for up to 21 days each calendar year. You do not need to complete your Elimination Period for Respite Care payments to begin, and the days you are receiving Respite Care will count toward satisfying your Elimination Period.

Respite Care can be provided in your home, an LTC Facility, an Adult Day Care Facility or a similar facility approved by us. Such payments will reduce your Lifetime Maximum Benefit, and will no longer be available once your Lifetime Maximum Benefit has been reached.

INTERNATIONAL BENEFITS

If you have selected a Home Care Monthly Benefit, we will pay International Benefits on an indemnity basis, if you qualify under the conditions defined in this provision.

ELIGIBILITY FOR INTERNATIONAL BENEFITS

You will be eligible for International Benefits if, after the effective date of your coverage and while your coverage is in effect, you become Chronically Ill.

CONDITIONS FOR PAYMENT OF INTERNATIONAL BENEFITS

To receive International Benefits under this Certificate, the following conditions must be met:
- you must satisfy the Elimination Period;

- you must be receiving Qualified Long Term Care Services while traveling or residing outside of the United States, its territories or possessions or Canada;
- the treatment for your Chronic Illness must be provided pursuant to a written Plan of Care; and
- we must approve your claim.

The policy is intended to be a qualified long term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. You must also provide us a Licensed Health Care Practitioner's Certification that you are unable to perform (without Substantial Assistance from another individual) two (2) or more Activities of Daily Living for a period of at least 90 days, or that you require Substantial Supervision by another individual to protect you from threats to your health or safety due to Severe Cognitive Impairment.

You must obtain and provide us with any required supporting documentation. All required documentation must be provided to us in English. We reserve the right to require that you provide us with updated documentation and information at reasonable intervals. However, we will not require updates more frequently than monthly.

We reserve the right to obtain an interpreter, if necessary, and to determine who the interpreter will be.

If you are receiving International Benefits under this Certificate, you cannot be receiving any other benefits under this Certificate for the same time period. Coverage for the Additional Care, Respite Care or Bed Reservation provisions are not available outside the United States, its territories or possessions or Canada.

LIMITATIONS ON PAYMENT OF INTERNATIONAL BENEFITS

We will not pay benefits in excess of the amounts shown in your **Schedule of Benefits**. Benefits paid will reduce your Lifetime Maximum Benefit and will no longer be available once your Lifetime Maximum Benefit has been reached.

INDEMNITY BENEFIT FOR PAYMENT OF INTERNATIONAL BENEFITS

The Indemnity Amount we will pay for International Benefits is equal to 75% of the Home Care Monthly Benefit shown in your **Schedule of Benefits**. Any International Monthly Benefit will be paid in United States currency. You may not assign the Indemnity Benefit.

TOTAL LIFETIME INTERNATIONAL BENEFITS AVAILABLE

The Total Lifetime International Benefit payment will be the lesser of:
- your Lifetime Maximum Benefit; or
- 72 months.

WORDS THAT HAVE A SPECIAL MEANING FOR THIS PROVISION

"Indemnity Amount" means the total monthly benefit available to you regardless of the actual charges you incur. This benefit will be paid to you if you are eligible under this Certificate for International Benefits. You must be receiving Qualified Long Term Care Services in order to receive the Indemnity Benefit.

"International" means any location outside the United States, its territories or possessions or Canada.

"International Benefit" means 75% of the Home Care Monthly Benefit shown in your **Schedule of Benefits**. This benefit will be paid to you regardless of who provides the care or where the care is provided, except for locations excluded by this Certificate.

EXTENSION OF BENEFITS

Termination of coverage will be without prejudice to any benefits payable under the policy and any attachments (if applicable), if eligibility for such benefits or Chronic Illness began while your coverage was in force. Benefits will continue without interruption. Such extension of benefits will be limited to the duration of the payment of your Lifetime Maximum Benefit.

LEGAL ACTION

No one may start legal action to recover on the policy until 60 days after written Proof of Claim has been given to us. Legal action must be started within four (4) years after the written Proof of Claim is furnished.

LIMITATIONS AND EXCLUSIONS

PLAN EXCLUSIONS

We will not provide benefits for:

- a Chronic Illness caused by war or any act of war, whether declared or undeclared, that occurs while your coverage is in force.
- a Chronic Illness caused by intentionally self-inflicted injuries or attempted suicide, while sane.
- a Chronic Illness caused by the participation in a felony, riot or insurrection.
- a Chronic Illness caused by alcoholism or drug addiction.
- any period of time while you are Chronically Ill and you are confined in a hospital, other than if you are confined to a LTC Facility that is a distinctly separate part of a hospital. This exclusion does not apply to those periods covered under the Bed Reservation Benefit.

OTHER SERVICES

ADDITIONAL CARE BENEFIT

Once you are eligible for a benefit payment you will have access to Additional Care designed to assist you in living at home or in other residential housing. You do not need to complete your Elimination Period for an Additional Care Benefit payment to begin. The Additional Care must be:
- appropriate for your Chronic Illness and conform with generally accepted medical standards;
- provided pursuant to a written Plan of Care;
- recommended by a Licensed Health Care Practitioner; and
- approved by us prior to receipt of Additional Care.

Payment of Additional Care Benefits will be coordinated with other insurance and/or Medicare.

We will require verification of Additional Care received. We will pay the actual expenses you incur for Additional Care, up to the Additional Care Benefit Lifetime Maximum. The Additional Care Benefit Lifetime Maximum is shown in the **Schedule of Benefits**.

The Additional Care Benefit:
- will be subject to written mutual agreement between you and us;
- may only be used for Additional Care as described under the policy;
- will not prejudice any payable claim for a covered Chronic Illness under the policy;
- will be restored under the Restoration of Benefits provision, if purchased;
- will reduce your Additional Care Benefit Lifetime Maximum;
- will not increase under any Inflation Protection benefit, if purchased; and
- will no longer be available once your Additional Care Benefit Lifetime Maximum has been reached.

If for any reason you do not wish to receive Additional Care, your benefits will continue according to the provisions of the policy.

WORDS THAT HAVE A SPECIAL MEANING IN THIS SECTION

"Additional Care" means special services, equipment or Caregiver Training designed to assist you in living at home or in other residential housing. Additional Care may include but is not limited to the following:
- assistance in locating long term care providers and caregivers in your area (this service is also available even if you are not eligible for benefits);
- assistance with arranging a visit from a Licensed Health Care Practitioner of your choice who will develop your Plan of Care;
- a visit from a home safety expert who will evaluate your residence and offer suggestions for increased personal safety;
- purchase or rental of a medical alert service;
- purchase or rental of durable medical equipment;
- home modifications for your support; or
- Caregiver Training.

"Additional Care Benefit Lifetime Maximum" means the total dollar amount of benefits that will be paid as Additional Care Benefit under the policy, as shown in your **Schedule of Benefits.**

"Caregiver Training" means the training of an informal caregiver to care for you in your home or in other residential housing. An informal caregiver may be a Family Member, relative or friend. We will not pay for training someone who is a Licensed Home Health Care Professional. Training can occur while you are confined in a hospital or a LTC Facility, if the training will make it possible for you to return to your home or to other residential housing where you will be cared for by the informal caregiver who received the training.

CLAIM INFORMATION

NOTICE OF CLAIM

You must notify us of your claim at our home office within 90 days of the date you experience a loss. The notice should include your name and the policy number. If it is not possible for you to give us notice within this time period, it must be given as soon as reasonably possible.

CLAIM FORM

We will send you our initial claim form and Authorization to Disclose Information when we receive your notice of claim. If you do not receive our forms within 15 days after notice of claim is given, you can send us written proof of claim without waiting for the forms.

HOW TO FILE A CLAIM

You or your authorized representative must fully complete the claim form, attaching additional pages if more space is needed, to fully describe your condition and care needs. The claim form and Authorization to Disclose Information must be signed by you, or by your authorized representative (such as a person to whom you have granted Power of Attorney).

PROOF OF CLAIM

You must give us initial proof of claim, at your expense, no later than 90 days after the date your loss begins. If it is not possible for you to give proof within this time limit, we will not reduce or deny your claim if proof is given as soon as reasonably possible. However, proof of claim must be given no later than one (1) year after the time proof is otherwise required, unless you are legally incapacitated.

The proof of your claim must include:
- the date your Chronic Illness began;
- the cause of your Chronic Illness;
- the extent of your Chronic Illness; including restrictions and limitations preventing you from performing the ADLs;
- a Licensed Health Care Practitioner's Certification;
- a copy of your Plan of Care;
- a Physician's statement and/or copies of relevant medical records from any Physician or health care provider involved in your care;
- the name and address of any hospital or institution where you received treatment, and/or the name and address of any health care provider who treated you, including all attending Physicians: and
- verification of care or services provided.

In addition to the claim form and the Authorization to Disclose Information, we may require, at our expense, that you or your caregiver provide or participate in one (1) or more of the following as proof of claim:
- an Assessment;
- a personal interview with you or review of your records by our representative at such time and with such frequency as we reasonably require;
- an independent medical examination or functional capacity evaluation. This may include related tests, as are reasonably necessary to the performance of the examination or evaluation by a Physician or specialist, appropriate for the condition at such time and place and with such frequency as we reasonably require. We reserve the right to select the examiner. We will pay for the examination, including the costs associated with your travel to the examination, if the examination cannot be conducted locally; and /or
- such other proof as we may deem necessary.

"Assessment" means a personal interview of you, done by us or our representative, to assist in the determination of your Chronic Illness at the time of your claim.

We reserve the right to request additional information necessary to our claim determination from you, your Physician, or other health care providers. You must promptly sign and return any forms we require in order to process your claim.

We will request proof of continued Chronic Illness or an updated written Plan of Care at intervals determined by us, but no more frequently than every 90 days.

You will also be required to submit a Licensed Health Care Practitioner's Certification every 12 months, as required under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

You or your representative(s) must respond within 30 days of the request for an updated Plan of Care, proof of continued Chronic Illness or additional information for us to continue to evaluate and process your claim. We reserve the right to deny your claim or stop sending you payments if the appropriate information is not submitted.

You or your representative(s) must notify us immediately when you are no longer Chronically Ill or you are no longer receiving Qualified Long Term Care Services.

WHEN CLAIMS ARE PAID

Benefits payable under the policy will be paid immediately for each day for which you were entitled to benefits during the prior month. Benefit payments will end as provided in the **TERMINATION OF BENEFITS** provision.

TO WHOM CLAIMS ARE PAID

All benefits are payable directly to you unless at the time of claim you or your authorized representative have requested in writing that payment be made otherwise.

If you are eligible to receive a benefit and you die prior to receiving the benefit payment, any remaining benefits that are owed to you will be payable to your probate estate, if one has been established. In the event that there is no probate estate, the remaining benefits will be paid, at our option, to your Family Member or to another recipient deemed by us to be entitled to such benefits. If we pay benefits in good faith under this provision, we will have satisfied our obligations under the policy and will not have to pay such benefits again.

CLAIM OVERPAYMENT

If for any reason benefits have been paid for a period for which you were not entitled to benefits, repayment of the overpayment must be made to us within 45 days of the notice to you or your representative. We may recover any amounts not repaid by offsetting them against any amounts otherwise payable to you under the policy or by other reasonable means, such as billing you or pursuing recovery through legal action.

CLAIM DENIAL

If your claim is denied, we shall make available all information directly relating to such denial within 60 days of the date of your written request, unless such disclosure is prohibited under state or federal law.

RIGHT OF APPEAL

You have the right to appeal any claim decision. Your appeal must be in writing and must be sent to us within 90 days of your denial notice.

We will notify you in writing if a claim or any part of a claim is denied. The denial letter will state:
- the specific reason(s) for the denial with reference to the applicable policy provision(s);
- a description of any additional material or information that is necessary to complete the claim;

- an explanation of why the additional material or information is necessary;
- a statement describing your access to documents; and
- a statement describing your appeal and legal rights to bring suit.

If you are not satisfied with the reason for the denial, you or your authorized representative may ask to have the claim reviewed by us. Your appeal must be in writing and should include all supporting materials or information that will help us to review the claim. We will review your appeal and all new information submitted, and notify you or your representative of our decision within 60 days of receiving the appeal. 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 we expect to make a decision. A decision shall be made no later than 120 days following receipt of the initial request for review. We can extend the time periods if we have not received needed information from you. In some cases, we may request that you provide additional information to assist in the review.

You or your authorized representative may request copies of those documents that are relevant to your claim.

GENERAL INFORMATION

PREMIUM DUE DATES AND PAYMENTS

All premiums due for your coverage, including any adjustments, must be paid on or before the applicable Premium Due Date. Premium must be sent to us at 2211 Congress Street, Portland, Maine 04122 or at the address designated on the bill for that purpose. Premiums are payable in U.S. currency only.

GRACE PERIOD

The Grace Period for coverage that is billed directly to you and/or your designated representative is the 45 consecutive days that begin with the day a premium is due. Your coverage will remain in effect during the Grace Period. Termination will not prejudice any payable claim for a covered loss that begins prior to the termination of coverage.

If Unum, at its sole discretion, agrees to waive your Grace Period in any instance, such agreement will not preclude or prejudice enforcement of your Grace Period in any other instance.

UNINTENTIONAL LAPSE FOR DIRECT BILLED COVERAGE

When you applied for this coverage, you were given the opportunity to designate at least one (1) person, in addition to yourself, who is to receive notice of lapse or termination of your coverage for nonpayment of premium. Designation does not constitute acceptance of any liability by the third party for services provided to you. You will be notified of your right to change this written designation no less often than once every two (2) years.

Your coverage will not lapse or be terminated for nonpayment of premium unless we notify you, and those persons designated by you (if any) to receive notice of lapse or termination, at least 30 days before the effective date of lapse or termination. Notice will be given by first class United States mail, postage prepaid. Notice will not be given until 30 days after a premium is due and unpaid and will be deemed to have been given as of five (5) days after the date of mailing. However, termination of your coverage will not prejudice any payable claim for a covered loss which begins prior to policy termination.

If premium payment for your coverage changes from payroll deducted to direct billed, you will have 60 days after you are no longer on the payroll deduction plan to designate at least one (1) person, in addition to yourself, to receive notice of lapse or termination of your coverage for nonpayment of premium.

REINSTATEMENT

If your coverage terminates because a premium is not paid by the end of the Grace Period, you may request to reinstate your coverage at any time within six (6) months after the policy's termination date. In order to reinstate coverage, the following requirements must be met:
- you must complete a Long Term Care Insurance Application;
- we must approve your Long Term Care Insurance Application; and
- you must pay all unpaid premium.

If we approve your reinstatement application, we will reinstate your coverage as of the date it was terminated and all of its terms and conditions will apply. If we issue a prepayment agreement and do not approve or disapprove your Long Term Care Insurance Application within 45 days from the date of the prepayment agreement, we will reinstate your coverage on that 45th day. The effective date of the reinstatement will be the date your coverage terminated.

The reinstated coverage WILL NOT exclude any Chronic Illness by name or description except those listed in the policy under the **LIMITATIONS AND EXCLUSIONS** provision.

The time periods under the **INCONTESTABILITY** provision will apply to coverage that is reinstated under this provision, and will be measured from the reinstatement date.

REINSTATEMENT OF TERMINATED COVERAGE DUE TO CHRONIC ILLNESS

If you become Chronically Ill and your coverage terminates because a premium is not paid by the end of the Grace Period, you may request to reinstate your coverage at any time within six (6) months after the policy's termination date.

In order to reinstate your coverage, you must provide proof that you are Chronically Ill and you must pay all unpaid premium.

If you meet these requirements, we will reinstate your coverage on the date your coverage terminated and all the terms and conditions of the policy will apply.

The reinstated coverage WILL NOT exclude any Chronic Illness by name or description except those listed in the policy under the **LIMITATIONS AND EXCLUSIONS** provision.

The time periods under the **INCONTESTABILITY** provision will apply to coverage that is reinstated under this provision, and will be measured from the reinstatement date.

REINSTATEMENT AFTER MILITARY SERVICE

You have the right to place your coverage in suspension while you are on a Leave of Absence from the Policyholder for active military service. "Suspension" is a process of placing your coverage on inactive status. No premium payments are required while coverage is suspended, but there is no coverage during that period of time. A request to suspend coverage due to entering full-time, active military service must be made in writing and include the policy number.

If the duration of your active military service is five (5) years or less and you return to Active Employment with the Policyholder within 90 days of the end of that service, your coverage will be reactivated without evidence of insurability so long as the policy remains in force. You must complete a written election to reinstate and pay the required premium.

If you do not terminate your full-time active duty within five (5) years from the date your coverage was suspended, or you do not reactivate your coverage within 90 days following your return to Active Employment with the Policyholder, your coverage will be deemed terminated as of the date suspension began. If your coverage has terminated, you may re-apply for coverage with evidence of insurability by filling out the benefit election form and the Long Term Care Insurance Application so long as the policy remains in force.

WAIVER OF PREMIUM

After you have satisfied your Elimination Period, and while you are receiving benefits under the policy and any attachments, we will waive premium payments. However, premium payments will not be waived if you are only receiving Respite Care Benefits or Additional Care Benefits.

If benefits are no longer payable, you must resume premium payments. We will notify you of the amount of your next premium payment and the date it is due.

RETURN OF PREMIUM AFTER DEATH

If you die while insured under the policy, we will return any pro rata portion of your premium paid covering the period after your death. The return of premium will be made within 30 days after we receive written notice of your death. Payment will be made to your estate.

RETURN OF PREMIUM DUE TO CANCELLATION OF COVERAGE

In the event your coverage under the policy is cancelled by you, we will, within 30 days of the effective date of such cancellation, return the premium paid for any period beyond the end of the month following the date of cancellation of coverage. The cancellation date will be determined as the date written notification was received by us. The return of premium will be made after we receive written notice of your cancellation request.

CONTINGENT NON-FORFEITURE

If your premium rates increase to a level which results in a cumulative percentage increase in your annual premium over your initial annual premium, that is greater than or equal to the percentage shown in the chart below based on your original issue age, you may choose to do one (1) of the following:

(a) continue to pay the required premium;
(b) reduce your benefits provided by the current coverage without the requirement of underwriting so that your required premium payments are not increased;
(c) elect to convert your coverage within 120 days of the premium increase effective date to a paid up status with Contingent Non-Forfeiture; or
(d) terminate your group coverage within 120 days of the premium increase effective date and be automatically converted to Contingent Non-Forfeiture.

The percentage increase in premium does not include increases to premium due to changes you request be made to your Long Term Care insurance coverage.

If you stop making premium payments under (c) or (d) above, this means that the Certificate will continue automatically with the same level of benefits, except for a reduction in your Lifetime Maximum Benefit. Your Lifetime Maximum Benefit under this provision will be equal to the total premium paid up to the date you stopped paying premiums minus the total amounts of benefits already paid to you.

In no event will your Lifetime Maximum Benefit:
- be less than 30 days of your LTC Facility Monthly Benefit; or
- exceed that which would have been paid had you not stopped paying premiums.

If your coverage contains an Inflation Protection Benefit option, Return of Premium at Death option and/or Restoration of Benefits option, no Inflation Protection Benefit, Return of Premium at Death or Restoration of Benefits will be made after the end of the period for which premiums were last remitted to us for your coverage.

Triggers For A Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%

65	50%	78	24%

MISSTATEMENT OF AGE

If your age has been misstated, any benefit payable will be changed to the amount which the premium paid would have bought for the correct age.

If we accept premium for coverage that we would not have issued or which would have ceased according to the correct age, our only liability is to refund the premium for the period not covered.

CLERICAL ERROR

Clerical error or omission by us will not:
- prevent you from receiving coverage or benefits;
- entitle you to receive coverage or benefits;
- affect the amount of your coverage; or
- cause your coverage to begin or continue when the coverage would not otherwise be effective.

CONFORMITY WITH FEDERAL STATUTES

We have designed the policy to meet the qualified long term care insurance requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended. In the future if changes are needed to maintain the tax status of the policy, we will make every reasonable effort to amend the policy to maintain its tax status. The Policyholder will be given the opportunity to amend the policy in order to preserve its favorable federal income tax treatment. Your Certificate may be affected by any such amendments. If the required changes are not made, the policy and your coverage may lose their status as a qualified long term care insurance policy.

CONFORMITY WITH STATE STATUTES

Coverage under the policy may be amended as required to reflect the minimum requirements of applicable state law.

TAX NOTE

Since benefits are paid without regard to actual charges you incur, part of the benefit could be considered taxable income if they exceed the daily benefit amount limit prescribed under Section 7702B(b) of the Internal Revenue Code of 1986, as amended (referred to as a "Per Diem" limit). This "Per Diem" limit is indexed for inflation. You should consult with your tax advisor.

ADDITIONAL BENEFITS

The Additional Benefits available under the policy are described in this section. Refer to your **Schedule of Benefits** for any Additional Benefits you may have selected.

INFLATION PROTECTION

If your coverage includes:

5% SIMPLE INFLATION PROTECTION

Your LTC Facility Monthly Benefit will increase each year on the Coverage Effective Date anniversary by 5% of your original LTC Facility Monthly Benefit. Increases will be automatic and will occur regardless of your health and whether or not you are eligible for or are receiving benefit payments under the policy and attached rider(s). Your premium will not increase due to automatic increases in your LTC Facility Monthly Benefit. Your remaining Lifetime Maximum Benefit Amount will also increase 5%.

In the event you decide to terminate this Inflation Protection prior to a benefit being paid, you have the right to purchase the inflated benefit amount at your original issue age or you can revert the benefit amount to the one you chose when you enrolled for this provision.

TERMINATION OF 5% SIMPLE INFLATION PROTECTION

Your Simple Inflation Protection will terminate on the earlier of:
- the day your coverage continues under any Non-Forfeiture Benefit; or
- the day your coverage terminates as provided in the Termination of Coverage provision.

Additional Claim and Appeal Information

APPLICABILITY OF ERISA

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

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. 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 Policy unless a shorter time is stated in the Policy.

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

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

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

APPEAL PROCEDURES

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 Policy.

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 Policy.

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 a 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 Policy 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.

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 eligibility 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 evaluating those decisions.

Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. 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 pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization 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. We may share NPI with parties to 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 and any applicants who receive an adverse underwriting decision.

Please be assured 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. For example, we do not sell your name to catalog companies.

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 and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. 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 NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you 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. It should also include 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. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have 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.

Contacting Us
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C467, Portland, Maine 04122. 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, 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 The Paul Revere Variable Annuity Insurance Company.

MK-1883 (10-10)

unum®

UNUM'S NOTICE OF PRIVACY PRACTICES

For Long Term Care, Cancer Assistance, Certain Medical Coverages and other Health Plans* Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Unum Understands the Importance of Your Privacy

This Notice describes your rights concerning "protected health information" ("PHI") about you. PHI is information that may identify you and that relates to (a) your past, present, or future physical or mental health or condition or (b) the past, present or future payment for your health care.

Unum is committed to preserving the confidentiality of PHI about its customers and in accordance with the requirements of the law, we pledge to:

- maintain the privacy of PHI about you
- provide you with a notice of our legal duties and privacy practices with respect to PHI
- abide by the terms of our current notice of privacy practices

It may be necessary to change the terms of this Notice in the future. We reserve the right to make changes and to make the new notice effective for all PHI that we maintain about you, including PHI we created or maintained in the past. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by a health plan.

Uses and Disclosures of PHI for Treatment, Payment or Operations

- *For Treatment* - Unum is not a health care provider and does not engage in "treatment" of individuals as a health care provider (a doctor, for example) would. Accordingly, although we are permitted to use or disclose PHI about you for treatment purposes, we do not do so.
- *For Payment* - We may use and disclose PHI about you in order to obtain premiums or to determine or fulfill our responsibility to provide you with insurance coverage or benefits under your policy. For example, we may use or disclose PHI about you in order to determine whether you are eligible for coverage or to decide your claim for benefits under your policy.
- *For Health Care Operations* - We may use and disclose PHI about you in order to operate our business. For example, we use PHI about you in order to underwrite your insurance policy.

*A "health plan" under the HIPAA Standards for Privacy of Individually Identifiable Health Information is an individual or group plan that provides or pays the cost of medical care.

Uses and Disclosures in Special Circumstances

Public Health Activities. We may disclose PHI about you in order to notify public health authorities of public health risks, such as potential exposure to a communicable disease, or to report child abuse or neglect.

Health Oversight Activities. We may disclose PHI about you to a health oversight agency for oversight activities, including for investigations relating to possible insurance fraud.

Judicial and Administrative Proceedings. We may disclose PHI in the course of a judicial or administrative proceeding, such as in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may disclose PHI to law enforcement, for purposes such as reporting a crime on our premises or in an emergency. We may also disclose to law enforcement or a correctional facility PHI relating to inmates as necessary for health, safety and security.

Prevention of Serious Harm. We may use or disclose PHI about you if we believe it is necessary to prevent or lessen serious harm (abuse, neglect, or domestic violence) to you or to other potential victims.

Serious Threat to Health/Safety. We may use or disclose PHI when it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Specialized Government Functions. We may use or disclose PHI about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities.

Workers' Compensation. We may disclose PHI about you in order to comply with workers' compensation laws.

Research Organizations. We may disclose PHI to research organizations if the organization has satisfied certain conditions about protecting the privacy of PHI.

Plan Sponsors. We may disclose PHI to the plan sponsor of a group health plan for plan administrative functions if the plan documents contain provisions concerning restrictions on how the plan sponsor may use or further disclose PHI.

Related Benefits and Services. We may contact you to inform you of benefits or services related to your policy that may be of interest to you.

Decedents. We may disclose PHI to a coroner, medical examiner, or funeral director to permit them to carry out their legal duties.

Donation/Transplantation. We may use or disclose PHI for the purpose of facilitating organ, eye or tissue donation and transplantation.

Business Associates. We may disclose PHI to our business associates, such as our third-party administrators, accountants, or attorneys if those business associates have signed a written agreement concerning appropriate uses and disclosures of PHI.

Involvement in Individual's Care. We may disclose PHI about you to a family member, close personal friend or other person identified by you if directly relevant to that person's involvement with your care or payment related to your health care.

Notification of Location/Condition. We may use or disclose PHI to give notice or assist in giving notice of your location, general condition or death to a family member, personal representative or another person responsible for your care.

Disclosures Required by Law. We will use and disclose PHI about you when we are required to do so by federal, state, or local law.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, we will restrict our uses or disclosure of PHI in accordance with the more stringent standard.

Uses and Disclosures of PHI Made Only With Your Written Authorization

Other uses and disclosure of PHI about you will be made only with your written authorization, unless otherwise permitted or required by law as described in this notice. You may revoke your written authorization, at any time, in writing, except to the extent we have taken action in reliance on that written authorization before you have revoked it. You may not revoke your authorization to the extent that other law provides us with the right to contest a claim under the policy or the policy itself, if the authorization was obtained as a condition of obtaining insurance coverage.

Your Rights

Right to a Paper Copy of this Notice. An electronic copy of this Notice is available on our website, www.Unum.com. If you would like to have another paper copy of this Notice, send a written request to the Unum Privacy Officer.

Inspection and Copying. You have the right to access your information. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). You have the right, upon written notice, to inspect and copy certain PHI that may be used to make decisions about your insurance coverage, including medical records and billing records, but not including psychotherapy notes. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial.

Amendment. You may ask us to amend PHI about you (as long as the information is kept by or for us) if you believe it is incorrect or incomplete. Such requests must be in writing to the Privacy Officer and must include a reason for the request. If your request and a reason supporting the request are not submitted in writing, we may deny your request.

Alternative Contact Information. You have the right to receive communications of PHI about you from us in a certain manner or at a certain location, so long as the request is reasonable under the circumstances. For example, you may prefer to have mail from us sent to your work address rather than to your home. Submit requests for an alternative method of contact in writing to the Privacy Officer.

Requesting Restrictions. You have the right to request restrictions on our use or disclosure of PHI about you. We are not required to agree to your request. If we do agree, however, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary for your treatment. Your request must clearly and concisely describe (a) the information you wish restricted; (b) whether you are requesting to limit our use, disclosure or both; and (c) to whom you want the limits to apply.

Accounting. You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures we have made of PHI about you other than disclosures you authorized and other than disclosures made for treatment, payment or operations. The request must be in writing. The first request for an accounting that you make within a 12-month period is free; however, we may charge you for additional requests within the same 12-month period. We will notify you of the costs of the additional requests, and you may withdraw your request before incurring any costs.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of Health and Human Services. All complaints must be submitted in writing. We will not penalize you for filing such a complaint.

In order to exercise any of your rights as set forth in this Notice, please write to:

Privacy Officer
Unum
2211 Congress Street, C467
Portland, ME 04122

For further information about matters covered by this notice, please contact the Privacy Office at the above address or call 1 (800) 227-4165 if you are a Long Term Care customer or 1 (800) 635-5597 if you are a Cancer Assistance customer.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, 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 The Paul Revere Variable Annuity Insurance Company.

Effective Date of This Notice: April 14, 2003

G-73568 (06/08)

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

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

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

Eligibility for Protection by the Association

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

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:

1. The policyholder has a policy with a company domiciled in Texas;
2. The policyholder's state of residence has a similar guaranty association; and
3. The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

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

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

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

RATE INFORMATION SCHEDULE

This schedule forms a part of Group Policy No. 205655 001 issued to the Policyholder:

County of Travis

INITIAL PREMIUM RATES

Choice A

Benefit Duration: 3 years

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.31	46	.65	74	5.71
19	.31	47	.67	75	6.45
20	.31	48	.72	76	7.22
21	.31	49	.77	77	8.13
22	.31	50	.82	78	8.99
23	.31	51	.89	79	9.95
24	.31	52	.96	80	10.95
25	.31	53	1.02	81	12.07
26	.31	54	1.08	82	13.33
27	.31	55	1.16	83	14.74
28	.31	56	1.23	84	16.20
29	.31	57	1.31	85	17.90
30	.31	58	1.41	86	19.53
31	.32	59	1.53	87	21.08
32	.34	60	1.66	88	22.79
33	.35	61	1.81	89	24.62
34	.37	62	1.97	90	26.57
35	.39	63	2.12	91	28.34
36	.41	64	2.28	92	30.04
37	.43	65	2.53	93	31.44
38	.45	66	2.71	94	32.71
39	.48	67	3.01	95	33.59
40	.50	68	3.26	96	35.39
41	.52	69	3.53	97	36.89
42	.54	70	3.83	98	37.96
43	.57	71	4.20	99	39.12
44	.59	72	4.66	100	40.39
45	.62	73	5.16		

Choice B

Benefit Duration: 6 years

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.40	46	.81	74	7.10
19	.40	47	.84	75	8.01
20	.40	48	.90	76	8.95
21	.40	49	.96	77	10.07
22	.40	50	1.02	78	11.12
23	.40	51	1.11	79	12.31
24	.40	52	1.20	80	13.54
25	.40	53	1.27	81	14.92
26	.40	54	1.35	82	16.45
27	.40	55	1.45	83	18.14
28	.40	56	1.54	84	19.91
29	.40	57	1.64	85	21.94
30	.40	58	1.77	86	24.11
31	.42	59	1.92	87	26.24
32	.43	60	2.09	88	28.64
33	.45	61	2.27	89	31.28
34	.48	62	2.48	90	34.16
35	.50	63	2.67	91	36.74
36	.53	64	2.87	92	39.06
37	.55	65	3.17	93	40.69
38	.58	66	3.39	94	41.88
39	.61	67	3.76	95	42.29
40	.64	68	4.07	96	44.57
41	.66	69	4.40	97	46.43
42	.69	70	4.78	98	47.65
43	.72	71	5.24	99	48.86
44	.74	72	5.81	100	50.09
45	.78	73	6.42		

Choice C

Benefit Duration: Lifetime

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.58	46	.99	74	8.91
19	.58	47	1.02	75	10.12
20	.58	48	1.08	76	11.29
21	.58	49	1.15	77	12.68
22	.58	50	1.23	78	13.98
23	.58	51	1.33	79	15.43
24	.58	52	1.44	80	16.92
25	.58	53	1.53	81	18.61
26	.58	54	1.63	82	20.42
27	.58	55	1.75	83	22.39
28	.58	56	1.86	84	24.44
29	.58	57	1.99	85	26.75
30	.58	58	2.15	86	29.38
31	.60	59	2.33	87	31.96
32	.61	60	2.53	88	34.86
33	.63	61	2.77	89	38.05
34	.65	62	3.03	90	41.52
35	.67	63	3.28	91	44.54
36	.69	64	3.54	92	47.22
37	.72	65	3.94	93	49.00
38	.74	66	4.24	94	50.34
39	.77	67	4.72	95	50.85
40	.80	68	5.13	96	53.48
41	.83	69	5.55	97	55.76
42	.85	70	6.04	98	57.24
43	.88	71	6.62	99	58.74
44	.92	72	7.33	100	60.26
45	.95	73	8.08		

Choice D

Benefit Duration: 3 years

Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.49	46	1.03	74	9.08
19	.49	47	1.07	75	10.26
20	.49	48	1.14	76	11.48
21	.49	49	1.22	77	12.93
22	.49	50	1.31	78	14.29
23	.49	51	1.42	79	15.82
24	.49	52	1.53	80	17.41
25	.49	53	1.62	81	19.20
26	.49	54	1.72	82	21.20
27	.49	55	1.84	83	23.44
28	.49	56	1.96	84	25.76
29	.49	57	2.08	85	28.46
30	.49	58	2.24	86	31.07
31	.51	59	2.43	87	33.53
32	.54	60	2.64	88	36.24
33	.56	61	2.87	89	39.15
34	.59	62	3.13	90	42.27
35	.62	63	3.38	91	45.08
36	.65	64	3.63	92	47.78
37	.68	65	4.02	93	50.01
38	.72	66	4.30	94	52.02
39	.76	67	4.78	95	53.43
40	.80	68	5.18	96	56.29
41	.83	69	5.61	97	58.67
42	.86	70	6.09	98	60.38
43	.90	71	6.69	99	62.21
44	.94	72	7.42	100	64.24
45	.98	73	8.20		

Choice E

Benefit Duration: 6 years

Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.63	46	1.29	74	11.28
19	.63	47	1.34	75	12.73
20	.63	48	1.43	76	14.24
21	.63	49	1.52	77	16.02
22	.63	50	1.63	78	17.69
23	.63	51	1.76	79	19.58
24	.63	52	1.91	80	21.53
25	.63	53	2.02	81	23.74
26	.63	54	2.15	82	26.16
27	.63	55	2.30	83	28.85
28	.63	56	2.45	84	31.66
29	.63	57	2.61	85	34.89
30	.63	58	2.82	86	38.34
31	.66	59	3.05	87	41.73
32	.69	60	3.32	88	45.55
33	.72	61	3.62	89	49.75
34	.76	62	3.94	90	54.33
35	.79	63	4.25	91	58.43
36	.84	64	4.56	92	62.12
37	.88	65	5.04	93	64.72
38	.92	66	5.39	94	66.60
39	.97	67	5.98	95	67.27
40	1.02	68	6.48	96	70.88
41	1.06	69	7.00	97	73.85
42	1.10	70	7.60	98	75.78
43	1.14	71	8.34	99	77.72
44	1.19	72	9.24	100	79.66
45	1.24	73	10.21		

Choice F

Benefit Duration: Lifetime

Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.93	46	1.57	74	14.18
19	.93	47	1.62	75	16.09
20	.93	48	1.72	76	17.96
21	.93	49	1.83	77	20.17
22	.93	50	1.95	78	22.23
23	.93	51	2.11	79	24.55
24	.93	52	2.29	80	26.92
25	.93	53	2.43	81	29.59
26	.93	54	2.59	82	32.48
27	.93	55	2.78	83	35.61
28	.93	56	2.96	84	38.88
29	.93	57	3.16	85	42.54
30	.93	58	3.41	86	46.73
31	.95	59	3.70	87	50.83
32	.98	60	4.03	88	55.45
33	1.00	61	4.41	89	60.51
34	1.03	62	4.82	90	66.03
35	1.07	63	5.22	91	70.85
36	1.10	64	5.63	92	75.11
37	1.14	65	6.27	93	77.93
38	1.18	66	6.74	94	80.07
39	1.23	67	7.51	95	80.87
40	1.28	68	8.15	96	85.06
41	1.32	69	8.83	97	88.69
42	1.36	70	9.61	98	91.04
43	1.40	71	10.53	99	93.42
44	1.46	72	11.66	100	95.84
45	1.51	73	12.85		

Choice G

Benefit Duration: 3 years

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Inflation Protection: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	.76	46	1.62	74	9.79
19	.76	47	1.68	75	10.55
20	.76	48	1.78	76	11.58
21	.76	49	1.91	77	12.80
22	.76	50	2.03	78	13.89
23	.76	51	2.18	79	15.07
24	.76	52	2.34	80	16.25
25	.76	53	2.46	81	17.63
26	.76	54	2.59	82	19.14
27	.76	55	2.73	83	20.81
28	.76	56	2.87	84	22.50
29	.76	57	3.02	85	24.35
30	.76	58	3.21	86	26.29
31	.80	59	3.44	87	28.09
32	.84	60	3.69	88	30.05
33	.88	61	3.97	89	32.13
34	.93	62	4.26	90	34.24
35	.98	63	4.51	91	36.10
36	1.03	64	4.75	92	37.84
37	1.08	65	5.06	93	39.20
38	1.14	66	5.34	94	40.40
39	1.20	67	5.83	95	41.17
40	1.26	68	6.22	96	43.07
41	1.31	69	6.61	97	44.61
42	1.36	70	7.07	98	45.71
43	1.42	71	7.62	99	46.88
44	1.48	72	8.31	100	48.15
45	1.55	73	9.02		

Choice H

Benefit Duration: 6 years

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Inflation Protection: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	1.08	46	2.19	74	12.84
19	1.08	47	2.26	75	13.81
20	1.08	48	2.40	76	15.15
21	1.08	49	2.55	77	16.72
22	1.08	50	2.71	78	18.11
23	1.08	51	2.89	79	19.62
24	1.08	52	3.08	80	21.13
25	1.08	53	3.22	81	22.88
26	1.08	54	3.36	82	24.77
27	1.08	55	3.53	83	26.82
28	1.08	56	3.70	84	28.91
29	1.08	57	3.86	85	31.14
30	1.08	58	4.09	86	33.85
31	1.13	59	4.36	87	36.45
32	1.19	60	4.65	88	39.37
33	1.25	61	5.03	89	42.53
34	1.31	62	5.42	90	45.84
35	1.38	63	5.77	91	48.79
36	1.45	64	6.12	92	51.32
37	1.52	65	6.55	93	52.88
38	1.60	66	6.93	94	53.84
39	1.68	67	7.60	95	54.38
40	1.77	68	8.14	96	56.39
41	1.83	69	8.69	97	58.36
42	1.89	70	9.32	98	59.56
43	1.96	71	10.04	99	60.72
44	2.03	72	10.93	100	61.82
45	2.11	73	11.84		

Choice I

Benefit Duration: Lifetime

Home Care Benefit: Professional Home and Community Care
50% of the LTC Facility Monthly Benefit

Inflation Protection: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	1.34	46	2.70	74	15.79
19	1.34	47	2.79	75	17.09
20	1.34	48	2.95	76	18.73
21	1.34	49	3.13	77	20.64
22	1.34	50	3.32	78	22.32
23	1.34	51	3.54	79	24.16
24	1.34	52	3.77	80	25.97
25	1.34	53	3.94	81	28.06
26	1.34	54	4.11	82	30.26
27	1.34	55	4.32	83	32.60
28	1.34	56	4.52	84	34.98
29	1.34	57	4.72	85	37.45
30	1.34	58	5.00	86	40.68
31	1.41	59	5.31	87	43.79
32	1.48	60	5.67	88	47.28
33	1.55	61	6.13	89	51.03
34	1.63	62	6.62	90	54.94
35	1.71	63	7.05	91	58.28
36	1.80	64	7.48	92	60.78
37	1.89	65	8.05	93	61.79
38	1.99	66	8.53	94	62.41
39	2.09	67	9.37	95	63.03
40	2.20	68	10.05	96	64.46
41	2.27	69	10.73	97	66.63
42	2.34	70	11.51	98	68.03
43	2.42	71	12.39	99	69.42
44	2.51	72	13.47	100	70.77
45	2.61	73	14.58		

Choice J

Benefit Duration: 3 years
Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit
Benefit Increase: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	1.17	46	2.50	74	15.14
19	1.17	47	2.59	75	16.30
20	1.17	48	2.76	76	17.90
21	1.17	49	2.95	77	19.78
22	1.17	50	3.14	78	21.46
23	1.17	51	3.37	79	23.29
24	1.17	52	3.62	80	25.12
25	1.17	53	3.80	81	27.24
26	1.17	54	4.00	82	29.58
27	1.17	55	4.22	83	32.17
28	1.17	56	4.44	84	34.77
29	1.17	57	4.67	85	37.64
30	1.17	58	4.97	86	40.63
31	1.23	59	5.32	87	43.41
32	1.30	60	5.70	88	46.44
33	1.36	61	6.13	89	49.65
34	1.44	62	6.58	90	52.92
35	1.51	63	6.96	91	55.79
36	1.59	64	7.35	92	58.48
37	1.67	65	7.83	93	60.57
38	1.76	66	8.25	94	62.43
39	1.85	67	9.01	95	63.62
40	1.95	68	9.61	96	66.56
41	2.03	69	10.22	97	68.95
42	2.11	70	10.93	98	70.64
43	2.20	71	11.78	99	72.45
44	2.29	72	12.84	100	74.41
45	2.39	73	13.93		

Choice K

Benefit Duration: 6 years
Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit
Benefit Increase: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	1.66	46	3.39	74	19.84
19	1.66	47	3.50	75	21.35
20	1.66	48	3.71	76	23.41
21	1.66	49	3.94	77	25.83
22	1.66	50	4.19	78	27.98
23	1.66	51	4.47	79	30.32
24	1.66	52	4.76	80	32.66
25	1.66	53	4.97	81	35.37
26	1.66	54	5.20	82	38.29
27	1.66	55	5.46	83	41.46
28	1.66	56	5.71	84	44.68
29	1.66	57	5.97	85	48.13
30	1.66	58	6.33	86	52.31
31	1.74	59	6.73	87	56.33
32	1.83	60	7.19	88	60.85
33	1.92	61	7.77	89	65.73
34	2.02	62	8.38	90	70.85
35	2.13	63	8.91	91	75.40
36	2.24	64	9.46	92	79.32
37	2.35	65	10.12	93	81.73
38	2.47	66	10.71	94	83.20
39	2.60	67	11.75	95	84.04
40	2.73	68	12.58	96	87.14
41	2.83	69	13.43	97	90.19
42	2.92	70	14.41	98	92.04
43	3.03	71	15.52	99	93.85
44	3.14	72	16.89	100	95.54
45	3.26	73	18.29		

Choice L

Benefit Duration: Lifetime

Home Care Benefit: Total Choice Home Care
50% of the LTC Facility Monthly Benefit

Benefit Increase: 5% Simple

Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit	Age	Monthly Rate Per $100 of Monthly Benefit
18	2.08	46	4.18	74	24.40
19	2.08	47	4.31	75	26.42
20	2.08	48	4.56	76	28.94
21	2.08	49	4.84	77	31.90
22	2.08	50	5.13	78	34.50
23	2.08	51	5.47	79	37.34
24	2.08	52	5.83	80	40.13
25	2.08	53	6.08	81	43.37
26	2.08	54	6.36	82	46.77
27	2.08	55	6.67	83	50.38
28	2.08	56	6.99	84	54.05
29	2.08	57	7.30	85	57.87
30	2.08	58	7.72	86	62.87
31	2.18	59	8.21	87	67.68
32	2.29	60	8.76	88	73.07
33	2.40	61	9.47	89	78.86
34	2.52	62	10.23	90	84.90
35	2.65	63	10.89	91	90.07
36	2.78	64	11.56	92	93.94
37	2.92	65	12.45	93	95.49
38	3.07	66	13.19	94	96.45
39	3.23	67	14.49	95	97.41
40	3.39	68	15.53	96	99.62
41	3.51	69	16.58	97	102.98
42	3.62	70	17.80	98	105.14
43	3.75	71	19.15	99	107.29
44	3.88	72	20.82	100	109.36
45	4.03	73	22.53		

RATE GUARANTEE PERIOD

A change in premium rate will not take effect before April 1, 2016. However, we may change the premium rates when the terms of this policy change or as otherwise allowed under the Guaranteed Renewable provision.

PREMIUM DUE DATES: April 1, 2012 and the first day of each calendar month thereafter.

The effective date of this amendment is April 1, 2012.

Dated at Portland, Maine on January 17, 2012.

Attachment LTC-2

5.2 Describe the conditions under which the rates are guaranteed, under what circumstances rates can be changed, how long rates are guaranteed, and the minimum advance notice of a rate change that would be given. Proposer shall provide the first year price/premium and shall provide either price or formula to determine the cost for years 2 through 4.

Our proposed rates are firm and will be guaranteed for four years. Any changes made in plan design, funding level, or commissions could affect the rates.

Premiums are level and are based on the plan selected and age at the time of enrollment. In the future, if the group's rates increase or decrease, the insured would pay the new rate based on his or her age when originally enrolled and the plan selected at that time.

Premium rates can be adjusted after the rate guarantee has expired. However, rate changes must be state approved to become effective and must apply to all insureds in a defined class (such as state, industry type, age group). Please note that Unum's Long Term Care insurance is fully pooled from a risk perspective and that rates will not change based on a policyholder's specific claims experience.

In the event of a rate increase, Unum will work closely with Travis County to prepare for this change. We are committed to providing a 90-day advance notice. Please note that we have not increased premiums for any of our inforce GLTC employer group plans.

Note: Insured who choose to increase the benefit amount within their current plan design would retain their original age rates for the previous coverage and only the additional amount would be billed at attained age. However, for insureds who want to change plan design (i.e. duration, inflation, home care), all coverage is assessed at their attained age at the time of application.

5.3 Under what circumstances can the company cancel the group offering?

Unum's GLTC standard group insurance policy language includes a "no-cause" termination provision that allows the group policyholder to terminate for any reason (or no reason) with the required timeframe for notice of termination.

5.4 Describe the situations in which an automatic decline is issued for a new individual coverage application under simplified or full underwriting. Be specific about height/weight ratios, conditions, and any other factors that will result in an automatic decline.

This section is designed to assist you in understanding the underwriting criteria that will be used to determine insurability for Unum's Long Term Care insurance.

This is not intended to be a complete or all-inclusive list. As the long term care insurance market matures, so will the understanding of its risk. Therefore, the development of underwriting criteria should be considered an evolving process, and it should be understood that the assumption of risk will change as our understanding of the market and related risk increases.

General Underwriting Criteria:

We consider the following factors in determining an individual's insurability:

Is the applicant:

- **living independently?**
- **cognitively intact?**
- **able to perform all basic activities of daily living without human assistance (bathing, dressing, toileting, transferring, continence and eating)?**
- **able to perform most instrumental activities of daily living (telephone, finance,**

housework, laundry, transportation, shopping, meal preparation, mobility, and medications) without human assistance?
- In good medical condition for age, with no medical condition that would place the applicant at high risk of using long term care services in the foreseeable future (e.g., Parkinson's disease, Alzheimer's disease)?

It is possible that a loss of functional ability or a medical condition may exist at the time of application that is not long term in nature but makes the applicant uninsurable for an immediate period of time. In this situation, the applicant will be advised of his or her current uninsurable status and provided with a time frame for re-application.

The factors that generally lead to automatic rejection (i.e., rejection without further investigation of the health or functional status of the applicant) will be disclosure of, or information indicating existence of the following types of conditions:
- dependency in any of the activities of daily living;
- cognitive impairment;
- dependency in any two (2) of the instrumental activities of daily living (IADLs). The IADLs include, but are not limited to:
  - meal preparation
  - managing medication
  - housework
  - managing finances
  - shopping
- medical conditions generally considered to be linked with a need for use of long term care services. These may include, but will not be limited to:
  - Alzheimer's disease
  - amyotrophic lateral sclerosis
  - chronic pain
  - fibromyalgia
  - Huntington's Chorea
  - metastatic cancers
  - multiple sclerosis
  - myasthenia gravis
  - Parkinson's disease
  - polyarteritis
  - renal failure
  - scleroderma
  - senility
- beginning use within the recent past of medical equipment including, but not limited to, wheelchair, Hoyer lift, urinary catheter, walker or quad cane;
- a recent history of the following types of service when used to treat chronic conditions:
  - home care
  - adult day care
  - nursing home care
  - other personal care assistance
- dependency in two or more IADLs, in conjunction with certain conditions assessed by Unum and its medical authorities to put the individual at high risk for using long term care services in the future. Such conditions may include, but will not be limited to:
  - angina

- arthritis
- chronic obstructive pulmonary disease
- Guillian Barre Syndrome
- heart disease
- joint replacement

This is intended to provide a basic outline of the criteria used in accepting and/or rejecting individuals who apply for Unum's Long Term Care insurance. It should not to be considered a complete or all-inclusive list. The final determination about the insurability of anyone applying for coverage is at the sole discretion of Unum Life Insurance Company of America.

5.5 For individuals whose coverage is subject to underwriting approval, please explain both the simplified and full underwriting processes, including the following in your response:

5.5.1 When is coverage effective for applicants subject to underwriting?

The coverage will become effective on the date of approval. The premium for that coverage will be billed to the policyholder on or next following the first of the month after the coverage effective date.

5.5.2 What is your average turnaround time for processing an evidence of insurability application?

Once we receive all the necessary information (including medical records), applications are processed in less than five business days.

5.5.3 What percentages of evidence of insurability applications are approved? denied?

This approval percentage varies by age of applicant. According to our block of business, 85% of employees and spouses, and 65% of retirees and extended family members, are approved for coverage.

5.5.4 Can previously denied individuals reapply? If yes, under what conditions?

If an applicant is denied coverage, the individual may reapply for coverage in the future. For example, an applicant currently being treated for a medical condition that puts him or her at high risk may be declined until the treatment is complete, and the individual has remained treatment-free for a certain period. At that time, it may be appropriate to reapply to Unum.

5.5.5 Are interviews required as part of the underwriting process?

Telephone Interview	Not applicable
Face to face Interview	< age 70 – for cause 70 and older - always

5.5.6 How would Travis County be notified of underwriting decisions?

Once an application is approved, we will mail two copies of our Schedule of Benefits to Travis County's plan administrator. This document provides Travis County with the employee/spouse deduction amount and plan choice, as well as the effective date of coverage. One copy goes to the employee for his or her records, and the second copy is intended for Travis County's personnel files. Retirees and other extended family members receive confirmation notices at home.

In addition, if Travis County chooses the online medical underwriting status report option through our I-Services offering, approvals can be accessed daily since the information is refreshed each night. There is no additional charge for this service.

As part of our offer, we have provided an expanded Administrative Services Quote as a separate attachment for your review.

6.0 CLAIMS AND CUSTOMER SERVICE:

6.1 Describe the member support services available, including the following:

6.1.1 Whether a toll free number is available.

Yes, Unum provides a toll-free number for participant inquiries.

6.1.2 Location and hours of operation.

Unum's Long Term Care Contact Center is located in Portland, Maine. Customer service representatives are available from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday.

6.1.3 Average years of tenure of staff in the LTC unit.

Unum's Group Long Term Care Client Service employees have an average of three to four years of experience.

6.1.4 Call quality monitoring.

Unum's Contact Center emphasizes quality assurance through both the training and quality monitoring of our customer service specialists. The Contact Center staff reflects Unum's focus on providing world-class customer service through its philosophy of *"Every customer, every time, one at a time, right now!"*

MONITORING FREQUENCY

Four calls for each specialist is recorded randomly each month and evaluated for quality assurance.

TRAINING

Upon joining the Contact Center, each specialist receives focused classroom training about products, systems and workflow procedures from subject matter experts. This classroom training is followed by a mentoring period with senior specialists to also provide on-the-job experience.

During their first weeks with the Contact Center, specialists also attend a corporate-wide communications training workshop which includes techniques to effectively serve any call type or customer as well as role-playing followed by group performance critiques. This training is the basis of our Quality Assurance program.

One-on-one quality assurance coaching is provided by the customer service specialist's manager. Additional coaching and refresher training can be provided in both group and one-on-one settings by the quality assurance specialist team.

CALL EVALUATION

Calls are evaluated for quality assurance by the quality specialist team. Quality assurance scores are recorded and are an integral part of the customer service specialists' performance evaluations.

6.1.5 Average speed of answer for 2010.

Our Contact Center tracks statistics to ensure a service level of 80/40 (80 percent of calls handled in 40 seconds) and an abandonment rate of <5% (percent of calls that disconnect while waiting in queue). The telephone system is able to track call volume as well as all performance data related to inbound/outbound calls placed to the various 800 numbers. During 2010 our "service level" results were 78.4%.

6.1.6 Average call time for 2010.

Our average handle time during 2010 was 5:11. Average Handle Time (AHT) is defined as the total amount of time the customer service specialist spends talking to the customer on the call plus the wrap-up time spent in the After Call Work state afterwards.

6.2 Explain the claim submission process, information required to substantiate a claim, correspondence sent to the participant during the claim evaluation process, the average turnaround time for payment of claims, and how often a claimant must be re-substantiated.

CLAIM SUBMISSION AND SUBSTANTIATION

Unum's GLTC claim form can be accessed from our corporate website unum.com. Employees can download the form, complete it and send it to us. Medical information does not need to be submitted with the claim form since we will obtain the necessary data.

In addition, any insured or a representative (broker, plan administrator, family member or other legally designated representative) may initiate an LTC claim on behalf of an insured. However, the authorization to release information form must be signed by the claimant or a legally designated representative.

A Unum LTC Benefits Center specialist is primarily responsible for benefit determination. The LTC benefits specialist will thoroughly review all the information submitted with the claims to determine the level of impairment and prognosis, and request additional data if needed. A benefit determination may also include input from one of Unum's on-site physicians or nurses. Often, our staff physician will contact the primary care provider directly to seek clarification or gain further insight into the claimant's condition.

For more complex claims, multi-disciplinary forums are held to bring together the experience and perspectives of medical, clinical, rehabilitation and claims professionals and when appropriate, legal resources. These resources are available to provide guidance and clarification on our most complicated claims.

If the LTC benefits specialist has difficulty obtaining information, assistance may be requested from the insured or the representative to expedite the process. The

LTC benefits specialist may also request that a functional assessment be performed if there is a lack of information available to thoroughly evaluate the claim. The format of a functional assessment ranges from a conversation between a health care professional and the insured, to a complete evaluation by an independent medical examiner that is used to evaluate the claimant's ability to perform Activities of Daily Living, as well as information about cognitive ability. An assessment may not be necessary for every claim, and the LTC benefits specialist will notify the insured or the representative if an assessment is needed. Unum selects, arranges for and assumes the total costs for any independent assessment, and for contracts with independent agencies and examiners throughout the country.

The claimant or his or her representative is notified by phone of claim approval/rejection. We also provide notification in writing.

CORRESPONDENCE TO CLAIMANT

Status letters are sent to the claimant or the claimant's representative every 21 calendar days until the claim determination is made.

It is expected that the LTC benefits specialist will call the insured or the representative within 24 hours of the claim determination, and will also follow up with a written explanation. Making a phone call to an insured gives the opportunity for the insured or the representative to ask any questions that they may have about the decision.

To communicate payment information for the insured, the check stub serves as the EOB. In addition, the benefit determination letter will provide pertinent information about the approval of the claim, the calculation of the first payment and the schedule for subsequent payments.

ONGOING CLAIM ELIGIBILITY VERIFICATION

The LTC benefits specialist assigned to the file is responsible for evaluating initial as well as ongoing eligibility. Many of the same resources used to establish initial eligibility are used to verify continued eligibility. Unum will obtain updated medical records and information from professional and informal caregivers. In addition, we use our own on-site physician or nurses as needed to verify that continued ADL loss is reasonable based on the diagnosis.

CLAIM TURNAROUND

Unum acknowledges all claims by letter within three business days of receipt. Status letters are sent to the claimant or the claimant's representative every 21 calendar days until the claim determination is made.

Once Unum has received all necessary information, the claim determination will be made within two business days.

Note: The average elapsed time from receipt of the completed claim form to the claim determination is four to six weeks, but may vary depending on the timeliness of the claim filing and the documentation available from care providers.

6.3 With regard to payment of claims, explain the following:

6.3.1 What are the options for paying claims (direct deposit, check, payment directly to care provider or LTC facility, etc)?

Payment is made directly to the insured unless he or she has assigned benefits (in writing) to another party at the time of claim. Although we are not currently able to make electronic fund transfers, checks may be mailed directly to a bank.

6.3.2 For mailed payments, on which day of the month are payments sent?

Once a claim is approved, a monthly payment schedule is established for each customer based on the benefit begin date. For example, if a claimant's elimination period was satisfied on the 15th of the month, payments will be issued on the 15th of each month for as long as the claimant remains eligible. Monthly payments include benefits that have accrued during the prior month, so for example, a payment issued on February 15th will include benefits due for January 1st through the 31st.

6.3.3 In the event of power of attorney, will the company pay claims to the designated legal guardian?

Payment is made directly to the insured unless he or she has assigned benefits (in writing) to another party at the time of claim.

6.4 Describe the steps involved in appealing benefit denials.

When additional information in support of a denied claim is submitted, with or without a formal appeal, it is reviewed by the original claims examiner and a decision about how this information might impact the claims is made within 30 days.

Claimants may also request a full and independent review of any adverse decision. The appeal review process is the responsibility of our independent Benefits Center Compliance Department. An insured can appeal a claim within 90 days of the date of the decision letter. All appeals must be filed by the claimant in writing and should include new or additional information (including medical information) to support the appeal. In addition, the claimant may request copies of pertinent documents that were used to review his or her claim.

Members of the BCC Department are responsible for thoroughly analyzing the claim facts and either upholding the decision, requesting that additional investigation take place, or returning the file to the claim representative for further consideration if they disagree with the decision. A final decision will be made within 60 days following receipt of the written request for review. If special circumstances make additional processing time necessary, the claimant will be notified of the reasons for the delay. In this case, a decision will be made within 120 days following our receipt of the request for review. We will communicate the final appeal decision, including the reasons for the decision, to the claimant in writing.

6.5 Does the company offer negotiated discounts with any LTC care providers? If yes,

please describe the process used to certify the providers, include a list of the providers in the Austin Metropolitan area, and the average discount in the Austin Metro area.

Unum contracts with LifePlans, Inc. headquartered in Waltham, Massachusetts to offer insureds and their family members access to LTC services and equipment at discounted rates. LifePlans' Long Term Care Provider Pathway (www.lifeplansproviderpathway.com) is a nationwide network composed exclusively of LTC-related providers, from facility-based care including nursing facilities and assisted living, to community-based services such as home health care, adult day care, hospice care and respite care. The Pathway also includes providers of durable medical equipment. Discounts generally range from 6% to 30% off retail rates. Our insureds and their family members access the Pathway via a dedicated, toll-free number that is staffed during normal business hours. A message service is available for after-hours and weekend calls. Based on the caller's location and service needs, LifePlans' customer service representative will identify participating providers within the network, and a customized list with contact information will be sent to the caller via mail, fax or e-mail. All providers in the Provider Pathway must undergo a thorough credentialing process, and must meet established state licensing requirements. LifePlans currently has arrangements with nearly 8,000 providers and is actively pursuing other network relationships. We would be glad to provide a list of contracted providers once we are selected as a finalist.

8.0 COMMUNICATIONS AND ENROLLMENT:

8.1 Does the company offer online enrollment capabilities, to include encryption for online enrollment, with or including completion of any health questionnaires? If so please describe the services and any fees which may apply.

Yes. We continually work to develop and enhance both our enrollment and administrative capabilities. Our website enrollment process ensures ease of enrollment. Customers can choose from two levels of Web enrollment service: informational website with downloadable forms or informational website with an online enrollment component (electronic data collection)*. There is no additional cost for this service. Our Web capabilities were designed to meet the varying and unique needs of our customers.

For our application's security, we use SSL (Secure Sockets Layer). This is a security standard used by many merchants to keep their websites secure. It protects the safety, privacy, and reliability of payment data traveling over the Internet. SSL encrypts the channel between the browser and web server so only the intended parties can read certain data such as payment or customer information.

If the option for online enrollment is selected, employees who are enrolling must be matched with three unique identifiers to gain access. This information is then checked against the list of eligible employees from the employer before the employees can enter the site.

Please not that individuals who are required to submit evidence of insurability cannot complete the process online. They will need to download an enrollment form from the enrollment website, complete and sign the form, and submit it to Unum via the U.S. Mail.

available for accounts that meet specific requirements, such as 500 or more employees with 85% to 90% of them having access to a PC at their desk, an 8 to 10 week pre-enrollment period to prepare the website, a standard plan design.

8.2 What is specifically recommended to initially achieve high participation and to continue to grow participation in future years?

We believe the primary element of a successful enrollment strategy is the partnership established between the client and Unum. We will work with Travis County to develop a comprehensive communication/enrollment strategy that best

fits the needs your particular work site atmosphere. Travis County can help promote the benefits by distributing pre-enrollment materials and sponsoring attendance of meetings during work hours. When this partnership is successful, we can expect the enrollment to be successful.

A Unum enrollment manager will be assigned to manage Travis County's enrollment activities. The enrollment manager is dedicated to ensuring that the enrollers, Contact Center representatives and all others associated with Travis County's offering are fully briefed about all the plan specifics. Prior to the enrollment period, the policy-specific information will be distributed throughout our Customer Service area.

Individual licensed enrollers are also available to conduct informational meetings for employees and eligible family members. They are Unum employees, as opposed to commissioned independent contractors, and are trained and certified in our voluntary products and sales approach. Their job is to educate employees about the benefit offering and to assist employees in making an informed purchasing decision.

Unum's Contact Center staff is available from 8:00 a.m. to 8:00 p.m. (ET), Monday through Friday. Because the policy information is online and readily available, our staff can provide policy-specific information during the enrollment process and throughout the year as needed.

8.3 Provide sample communication materials, and sample enrollment forms that will be used.

PART II - SPECIFIC REQUIREMENTS

PART II, SECTION A - SPECIFIC REQUIREMENTS

1.0 GENERAL REQUIREMENTS:

1.1 All policy provisions must be in full compliance with Texas and Federal requirements relating to the Long Term Care coverage being requested.

Unum confirms that its insurance companies are in material compliance with all federal and state laws and statutes, regulations, and bulletins applicable to the services we are to perform.

1.2 Proposals must be on a fully-insured basis and the plans must be tax qualified.

Confirmed. Our fully-insured GLTC plans are intended to be tax qualified under Section 7702B(b) of the Internal Revenue Code.

1.3 It is not the intention of the County to be involved in the underwriting process. The selected insurance company must have procedures in place to interact directly with applicants for coverage.

Travis County would not be involved in the medical underwriting process; however, they can assist the employee by providing the Medical Underwriting form or letting the employee know that the form can be retrieved online.

After enrollment, the ongoing employer responsibilities would include managing employee eligibility, establishing employee and spouse payroll deductions, distributing applicable material to employees and spouses, and reconciling a monthly list bill.

2.0 **ELIGIBILITY DEFINITIONS:** The following categories of individuals are eligible to enroll:

2.1 Full-Time Active employees who work 20 or more hours per week.

Confirmed. Unum's eligible population includes:

- **active full-time employees working 20+ hours per week;**
- **retired employees;**
- **the legally married spouse of an employee or retiree;**
- **the domestic partner of an active or retired employee. A domestic partner is the person named in the active or retired employee's declaration of domestic partnership. The active or retired employee 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 the active or retired employee for a minimum of 12 consecutive months prior to the date insurance would become effective for that domestic partner. The active or retired employee 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 to 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;

- **the natural, adoptive or step-parents/grandparents of an active employee and their spouse or domestic partner;**
- **the natural, adoptive or step-siblings of an active employee and their spouse or domestic partner;**
- **the natural, adoptive or step-siblings of an active employee's sibling's spouse;**
- **the natural, adoptive or step-siblings of the employee's spouse.**
- **the natural, adoptive or step-children of an active employee and their spouse or domestic partner.**

Each person applies separately. There are no age restrictions on full-time active employees or retirees. Family members must be at least 18 and no more than 80 years of age in order to enroll in this program. Rates are based on the applicant's age, the plan design, and the options selected.

Note: Additional family members of retirees may be eligible for coverage with underwriter approval.

2.2 Family members of employees, including spouses, children, and Domestic Partners.

Confirmed.

2.3 Retirees of Travis County and their Eligible Family Members, including Domestic Partners.

Confirmed. Please refer to the information on Unum's Domestic Partner eligibility under 2.1 above.

2.4 Enrollment of dependents of employees/retirees is not conditional upon enrollment of the employee/retiree. As such, an employee or retiree may waive coverage, while enrolling a spouse or domestic partner.

Confirmed.

3.0 ENROLLMENT REQUIREMENTS:

3.1 Proposer acknowledges and understands the goal of the County is to provide employees and retirees the option to enroll during two time periods within the first year of the program. Proposers agree to the following:

3.1.1 The initial open enrollment period will be [redacted] During this time, coverage for all plan options will be guarantee issue for active employees, their dependents (including domestic partners), retirees and their spouses. No underwriting, including simplified underwriting, will apply during this initial enrollment period for individuals selecting Plan Options I-IV.

Unum agrees to allow an initial enrollment period for employees [redacted] as outlined above in 3.1. During these specific periods;

active, eligible employees can enroll for guarantee issue coverage without providing evidence of insurability. Employee coverage requested that exceeds the guarantee issue limit is subject to evidence of insurability. Medical underwriting is required for the Lifetime coverage duration option for employees. Medical underwriting is also required for any level of coverage for all other eligible family members and retirees.

During the initial enrollment period the minimum participation requirement of [redacted] (employee participation) must be met. This can be achieved by executing an enrollment strategy as outlined in section 8.2. Once that minimum participation is achieved, we will accommodate a second enrollment period immediately following the first as outlined below in section 3.1.2.

Subsequent to the initial enrollment [redacted], employees, retirees and all family members are medically underwritten, except for new hires enrolling during their initial waiting period.

Once approved for coverage, a person remains insured even if there is a change in health.

3.1.3 The selected Proposer will be allowed to apply additional underwriting requirements, as permitted by State and Federal regulatory guidelines, for coverage requests made outside of the enrollment periods listed above.

Subsequent to the initial enrollment and second enrollment period, employees, retirees and all family members are medically underwritten, except for new hires enrolling during their initial waiting period.

3.2 Under no circumstances can ported policies be cancelled if the County discontinues offering the voluntary LTC insurance.

For employees who elect to port coverage under our Continuation of Coverage provision, our policy states:

"If your coverage terminates because you are no longer eligible for coverage, your continued coverage will remain inforce under the existing group policy. If the

existing group policy terminates, your coverage will be continued under a group continuation policy. Your continued coverage will remain inforce as long as you continue timely payment of premium when due. You must pay premium directly to Unum for your continued coverage."

3.3 The LTC insurance company will provide knowledgeable and qualified enrollment staff, LTC information and materials to conduct enrollment meetings [redacted], and for subsequent annual open enrollment events, to include attendance at the New Employee Orientation (NEO) meetings.

Unum will assign an enrollment manager to work with you to develop a strategy for the initial open enrollment period and to determine an ongoing re-enrollment process.

3.4 Company will print, collate, and deliver all education and enrollment packets to each meeting location. Enrollment meetings will be held at the various Travis County facilities.

Confirmed. Unum will provide the enrollment material to Travis County for communications as well as the enrollment packets for each meeting.

3.5 Company will have an established toll-free support center for individuals to speak with a licensed LTC specialist about the plan options offered. The hours of operation must include 8 a.m. CST to 7 p.m. CST.

Unum's Contact Center is located in Portland, Maine, and available via a toll-free line. The Contact Center is staffed with trained specialists who can answer a wide variety of questions about our Group Long Term Care product, such as status of an application, promotional material, billing, inforce policy changes, policy reinstatements, claims help, or identifying group name, policy number, address or plan administrator. Customer service representatives are available from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday (7:00 a.m. to 7:00 p.m. CT).

In addition, Unum certified enrollers will support the group voluntary employee meetings. These enrollers must also hold their state Life and Health Insurance License prior to conducting any enrollment work for Unum. They are Unum employees and not commissioned independent contractors. Their job is to educate employees about the benefit offering and to assist employees in making an informed purchasing decision.

3.6 Company will have an established toll free customer service number supported by licensed and trained LTC specialists for contract holders with questions to contact. The hours of operation must include 8 a.m. CST to 7 p.m. CST.

Unum's Contact Center is located in Portland, Maine, and available via a toll-free line. The Contact Center is staffed with trained specialists who can answer a wide variety of questions about our Group Long Term Care product, such as status of an application, promotional material, billing, inforce policy changes, policy reinstatements, claims help, or identifying group name, policy number, address or

plan administrator. Customer service representatives are available from 8:00 a.m. to 8:00 p.m. ET, Monday through Friday (7:00 a.m. to 7:00 p.m. CT).

As stated above, Unum certified enrollers will support the group voluntary employee meetings. These enrollers must also hold their state Life and Health Insurance License prior to conducting any enrollment work for Unum. They are Unum employees and not commissioned independent contractors. Their job is to educate employees about the benefit offering and to assist employees in making an informed purchasing decision.

3.7 Upon approval for coverage, Company agrees to the following:

3.7.1 The County and the LTC applicant will be notified within 10 business days of approval for coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that Long Term Care carriers provide confirmations and booklets to insureds within 30 days of their effective date. Unum complies with this requirement.

For the initial implementation of this plan, we must receive all necessary information 30 days prior to the policy effective date, including:

- **a signed master application;**
- **completed Benefit Election forms, Evidence of Insurability forms (if applicable) from each participant in the plan and any state required regulatory forms;**
- **a binder premium (if applicable);**
- **the company's legal name;**
- **the employer identification number (EIN);**
- **the ERISA plan number;**
- **the divisions, subsidiaries or affiliates covered;**
- **the billing type – payroll or non-payroll;**
- **administrative requirements;**
- **description of eligible employees; and**
- **the plan design/schedule.**

For new hires and/or future applicants; once an application is approved, we will mail our Schedule of Benefits directly to the employee's home address. A second copy can also be provided to Travis County's plan administrator within 10 days of the approval. This document provides the employee and Travis County with the employee/spouse deduction amount and plan choice, as well as the effective date of coverage.

3.7.2 The LTC policy will be sent directly to the covered individual without the involvement of the County.

As the policyholder of this group product, the master contract is provided to Travis County. The participants will receive certificates under the policy. A Schedule of Benefits will be mailed to the employee providing confirmation of coverage with the employee/spouse deduction amount and plan choice, as well as the effective date of coverage. One copy goes to the employee for his or her records, and a second copy can be provided upon request to the Plan Administrator for Travis County's personnel files. Employee Certificates are generic and may also be mailed along with the Schedule of Benefits to the Employee's home or can be

provided to the Employee by the Plan Administrator by electronic delivery through email or by posting on their benefits website.

Plan booklets and Confirmation of Coverage Statements for all other insureds are mailed directly to their homes.

4.0 REMITTANCE OF PAYMENT FOR LTC PREMIUMS:

4.1 Premiums for active employees will be either payroll deducted or billed direct to employees. All other billings will be direct billed. If payroll deducted, the billing will be self billed. Proposers must specify what they expect in the contract. Proposers agree to allow a 30 day grace period from the due date of the premium to remittance.

Please note that Unum is not offering a self-accounting billing arrangement. In order to effectively reserve for future claims we must maintain all participant level data. As a result, a group list bill is provided to the employer on a monthly basis. As the policyholder of a Group plan, Travis County is responsible for reporting changes monthly and fully reconciling the monthly list bill. Only employees and spouses are group billed and are the responsibility of Travis County from an administrative perspective. Travis County is not administratively responsible for extended family members and/or retirees. These applicants are direct billed at their residence once they are approved by Underwriting.

Unum can offer reconciliation assistance for clients who have 500 or more enrolled employees in a 100% Voluntary plan. For this process Travis County must provide a complete file of payroll deductions per employee in our required format. Each month, we will provide a discrepancy report by comparing our billing information against Travis County's payroll deduction confirmation file. IT resources from both companies will be needed to implement this process.

In order to comply with the regulations for the State of Texas, the Unum policy will include a 31 day grace period for premium payment.

4.2 The selected Insurer will be required to bill and collect premiums directly from retirees or other dependents. Bidders agree to allow a 30 day grace period from the due date of the premium to remittance by retirees

Confirmed. Please note that the grace period for policies issued in the State of Texas is 31 days.

The premium is due on the first of the month. To avoid lapse in coverage or collections activity, Unum must receive premiums by the due date or within the grace period.

We allow insureds that are direct billed (extended family members and retirees), a 30-day grace period. However, for those insureds who have designated a third party to receive grace period expiration notices, the grace period is the 30-consecutive-day period that begins on the day the insured and/or designated representative has been notified that premium is 30 days past due.

5.0 EMPLOYEES TERMINATING EMPLOYMENT:

5.1 Employees terminating employment for any reason must have the option to continue their LTC coverage under the portability feature of the policy without evidence of insurability. Premiums for ported policies will be paid directly to the LTC insurance company without any involvement from the County.

Confirmed. Each insured has the legal right to continue their coverage through our contract's Continuation of Coverage provision. The insured may choose to be direct billed on a quarterly, semi-annual, or annual basis, or may choose to have monthly deductions made from his or her checking account through our Automatic Clearing House (ACH) option.

5.2 Premium rates for ported policies will on the same basis and structure as the premium rates for active employees and retirees. No surcharge is permitted for ported policies.

Policies are converted under our Continuation of Coverage provision with no change in rates, and there are no one-time expenses or fees applied.

Attachment E-1

STATE OF TEXAS}
COUNTY OF TRAVIS}

ETHICS AFFIDAVIT

Date: 2/28/2011
Name of Affiant: Aaron Shisler
Title of Affiant: Account Executive
Business Name of Proposer: Unum
County of Proposer: Harris County

Affiant on oath swears that the following statements are true:

1. Affiant is authorized by Proposer to make this affidavit for Proposer.

2. Affiant is fully aware of the facts stated in this affidavit.

3. Affiant can read the English language.

4. Proposer has received the list of Key Contracting Persons associated with this solicitation which is attached to this affidavit as Exhibit "A".

5. Affiant has personally read Exhibit "A" to this Affidavit.

6. Affiant has no knowledge of any Key Contracting Person on Exhibit "A" with whom Proposer is doing business or has done business during the 365 day period immediately before the date of this affidavit whose name is not disclosed in the solicitation.

Signature of Affiant

2000 West Sam Houston Pkwy South, Suite 1400
Houston, TX 77042
Address

SUBSCRIBED AND SWORN TO before me by [signature] on 2/28, 2011.

NICOLE A. ECKARD
MY COMMISSION EXPIRES
April 1, 2012

Notary Public, State of Texas

Nicole A. Eckard
Typed or printed name of notary
My commission expires: 4/1/2012

ATTACHMENT 1

EXHIBIT A
LIST OF KEY CONTRACTING PERSONS
February 28, 2011

CURRENT

Position Held	Name of Individual Holding Office/Position	Name of Business Individual is Associated
County Judge	Samuel T. Biscoe	
County Judge (Spouse)	Donalyn Thompson-Biscoe	MHMR
Executive Assistant	Cheryl Brown	
Executive Assistant	Melissa Velasquez	
Executive Assistant	Josie Z. Zavala	
Executive Assistant	Cheryl Aker*	
Commissioner, Precinct 1	Ron Davis	
Commissioner, Precinct 1 (Spouse)	Annie Davis	Seton Hospital
Executive Assistant	Chris Fanuel	
Executive Assistant	Felicitas Chavez	
Commissioner, Precinct 2	Sarah Eckhardt	
Commissioner, Precinct 2 (Spouse)	Kurt Sauer	Daffer McDaniel, LLP
Executive Assistant	Loretta Farb	
Executive Assistant	Joe Hon	
Executive Assistant	Peter Einhorn	
Commissioner, Precinct 3	Karen Huber	
Commissioner, Precinct 3 (Spouse)	Leonard Huber	Retired
Executive Assistant	Garry Brown	
Executive Assistant	Lori Duarte*	
Commissioner, Precinct 4	Margaret Gomez	
Executive Assistant	Edith Moreida	
Executive Assistant	Norma Guerra	
County Treasurer	Dolores Ortega-Carter	
County Auditor	Susan Spataro	
Executive Manager, Administrative	Vacant	
Executive Manager, Budget & Planning	Rodney Rhoades	
Exec Manager, Emergency Services	Danny Hobby	
Exec. Manager, Health/Human Services	Sherri E. Fleming	
Executive Manager, TNR	Steven M. Manilla, P.E.*	
Executive Manager, Criminal Justice Planning	Roger Jefferies	
Director, Facilities Management	Roger El Khoury, M.S., P.E.	
Chief Information Officer	Joe Harlow	
Director, Records Mgment & Communications	Steven Broberg	
Travis County Attorney	David Escamilla	
First Assistant County Attorney	Steve Capelle	
Executive Assistant, Civil Division	Jim Collins	
Director, Land Use Division	Tom Nuckols*	
Attorney, Land Use Division	Julie Joe	
Attorney, Land Use Division	Christopher Gilmore	
Director, Transactions Division	John Hille	
Attorney, Transactions Division	Tamara Armstrong	
Attorney, Transactions Division	Daniel Bradford	
Attorney, Transactions Division	Mary Etta Gerhardt	
Attorney, Transactions Division	Barbara Wilson	
Attorney, Transactions Division	Jim Connolly	
Attorney, Transactions Division	Tenley Aldredge	
Director, Health Services Division	Beth Devery	
Attorney, Health Services Division	Prema Gregerson*	

Purchasing Agent	Cyd Grimes, C.P.M.
Assistant Purchasing Agent	Marvin Brice, CPPB
Assistant Purchasing Agent	Bonnie Floyd, CPPO, CPPB, CTPM
Purchasing Agent Assistant IV	Diana Gonzalez
Purchasing Agent Assistant IV	Lee Perry
Purchasing Agent Assistant IV	Jason Walker
Purchasing Agent Assistant IV	Richard Villareal
Purchasing Agent Assistant IV	Oralia Jones, CPPB
Purchasing Agent Assistant IV	Lori Clyde, CPPB
Purchasing Agent Assistant IV	Scott Wilson
Purchasing Agent Assistant IV	Jorge Talavera, CPPB
Purchasing Agent Assistant IV	George R. Monnat, C.P.M., A.P.P.
Purchasing Agent Assistant IV	John E. Pena, CTPM*
Purchasing Agent Assistant III	Vacant
Purchasing Agent Assistant III	David Walch
Purchasing Agent Assistant III	Michael Long, CPPB
Purchasing Agent Assistant III	Elizabeth Corey, C.P.M.*
Purchasing Agent Assistant III	Rosalinda Garcia
Purchasing Agent Assistant III	Loren Breland
Purchasing Agent Assistant II	C.W. Bruner, CTP*
Purchasing Agent Assistant III	Nancy Barchus, CPPB
HUB Coordinator	Sylvia Lopez
HUB Specialist.	Betty Chapa
HUB Specialist.	Jerome Guerrero
Purchasing Business Analyst	Scott Worthington
Purchasing Business Analyst	Jennifer Francis*
HRMD Director	Diane Blankenship
HRMD Risk & Benefit Manager	Dan Mansour
HRMD	Cindy Purinton
Auditor Office	Karen Sonleitner
TNR	Howard Herrin
District Attorney Office	Vicki Skinner
Juvenile Defender Office	Terry Esquivel
Elections Office	Alexa Buxkemper

FORMER EMPLOYEES

Position Held	Name of Individual Holding Office/Position	Date of Expiration
Purchasing Agent Assistant III	Vania Ramaekers, CPPB, CPPO	04/26/11
Attorney, Transactions Division	Sarah Churchill	04/30/11
Executive Assistant	Chris Fanuel	04/30/11
Purchasing Agent Assistant II	Donald E. Rollack	05/31/11
Special Assistant to Comm. Court	Christian Smith	05/31/11
Executive Manager, TNR	Joseph Gieselman	01/31/12

* - Identifies employees who have been in that position less than a year.

Proposer acknowledges that Proposer is doing business or has done business during the 365 day period immediately prior to the date on which this proposal is due with the following Key Contracting Persons and warrants that these are the only such Key Contracting Persons:

Unum provides group life and disability insurance coverage to eligible employees of the County that may include all or some of the Key Contracting Persons.

If no one is listed above, Proposer warrants that Proposer is not doing business and has not done business during the 365 day period immediately prior to the date on which this proposal is due with any Key Contracting Person.

ATTACHMENT 2