



**GROUP INSURANCE POLICY
NON-PARTICIPATING**

POLICYHOLDER: Sacramento City Unified School District

POLICY NUMBER: 920555 001

POLICY EFFECTIVE DATE: November 1, 2022

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: California

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

The **Policyholder** should read the policy carefully and contact Unum promptly with any questions. The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

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

President

Secretary

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

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SCHEDULE OF BENEFITS_{you}

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for **you** by paying a portion of your income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before your **disability** began. In some cases, **you** can receive disability payments even if **you** work while **you** are disabled. Your **disability** must begin while **you** are covered under the long term disability plan.

All terms **bolded** are defined in the **GLOSSARY** section.

You must write your name and the date **you** received this certificate in the space provided so that it becomes your certificate of coverage. The date **you** are eligible for coverage is described in the **GENERAL PROVISIONS** section.

EMPLOYEE NAME:

DATE RECEIVED:

ELIGIBLE GROUP(S):

Group 1
All Full-Time Members of SEIU sTf [] 1 0 8lf 15sPI-

TOTAL BENEFIT CAP:

The total benefit payable to **you** on a monthly basis (including all benefits provided under this long term disability plan) will not exceed 100% of your **monthly pre-disability earnings** or your **maximum monthly benefit**.

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

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for **you** by paying a portion of your income while **you** are disabled. The amount **you** receive is based on the amount **you** earned before your **disability** began. In some cases, **you** can receive disability payments even if **you** work while **you** are disabled. Your **disability** must begin while **you** are covered under the long term disability plan.

All terms **bolded** are defined in the **GLOSSARY** section.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: November 1, 2022

POLICY NUMBER: 920555 001

ELIGIBLE GROUP(S):

Group 1

All Full-Time Members of SEIU Local 1021 in **active employment** in the United States with the **Employer**.

Group 2

All Permanent Part-Time Members of SEIU Local 1021 in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

the policy has been continued beyond its original term the **Employer** may cancel this policy at any time by written notice delivered or mailed to the insurer, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either the insurer or the **Employer**, the insurer shall promptly return on a

POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

Clerical error or omission by Unum will not:

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

WHO CAN CANCEL OR MODIFY THE POLICY OR A LONG TERM DISABILITY

If this policy or a long term disability plan is cancelled, the cancellation will not affect a **payable claim**.

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

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

Coverage will be continued until the end of the later of:

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

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

We will not:

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

CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes **you** as a client.

This is your certificate of coverage as long as **you** are eligible for coverage and **you** become insured. **You** will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If **you** have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist **you** in any way to help **you** understand your benefits.

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

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

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

Policyholder's Name: Sacramento City Unified School District

Policy Number: 920555 001

Policyholder's Original Plan Effective Date: November 1, 2022

Long Term Disability Plan: November 1, 2022

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

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

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

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

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

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

- the **Policyholder's** original effective date of coverage; or
- the day after **you** complete your **waiting period**.

WHAT IS AN ELIGIBLE GROUP?

Group 1

All Full-Time Members of SEIU Local 1021 in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

Group 2

All Permanent Part-Time Members of SEIU Local 1021 in **active employment** in the United States with the **Employer**.

Temporary and seasonal workers are excluded from coverage.

WHAT IS YOUR WAITING PERIOD?

The **waiting period** is a continuous period of **active employment** which **you** must satisfy before **you** are eligible for coverage.

For **employees** in an eligible group on or before November 1, 2022: None

For **employees** entering an eligible group after November 1, 2022: First of the month coincident with or next following the date **you** enter an eligible group

REHIRE:

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

WHEN DOES YOUR COVERAGE BEGIN?

When **you** become eligible for coverage under the plan, your **Employer** will automatically enroll you in the **PLÉGÀZ IÓD** coverage will begin at 12:01 a.m. on the _

date **you** are eligible for **COVERAGE** **you** do not want coverage under the plan, **you** may choose to decline this coverage and coverage under the plan will not go into effect.

If **you** apply for coverage in the future or voluntarily cancelled your coverage and are **REPLACING EVIDENCE OF INSURABILITY** **COVERAGE** will begin at 12:01 a.m. on the date Unum approves your **evidence of insurability** **DATE**

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

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

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

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

If **you** are on a temporary **layoff**, and if premium is paid, **you** will be covered for up to 12 months following the date your temporary **layoff** begins.

If **you** are on a **leave of absence**, and if premium is paid, **you** will be covered for up to 12 months following the date your **leave of absence** begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

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

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

WHEN DOES YOUR COVERAGE END?

Your coverage(s) under the policy ends on the earliest of:

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

However, coverage will continue:

- while benefits are being paid;
- while **you** are fulfilling the requirements of your **elimination period**, so long as premium is being paid; or
- in accordance with the **layoff** and **leave of absence** provisions of the policy.

LONG TERM DISABILITY

- obtain, with your cooperation and authorization if required by law, only such information that is necessary to evaluate your claim and decide whether to accept or deny your claim for benefits. **We** may obtain this information from your notice of claim, submitted proofs of loss, statements, or other materials provided by **you** or others on your behalf; or, at **our** expense **we** may obtain necessary information, or have **you** physically examined when and as often as **we** may reasonably require while the claim is pending. In addition, and at your option and at your expense, **you** may provide **us** and **we** will consider any other information, including but not limited to, reports from a **physician** or other expert of your choice. **You** should provide **us** with all information that **you** want **us** to consider regarding your claim;
- consider and interpret the policy and all information obtained by **us** and submitted by **you** that relates to your claim for benefits and make **our** determination of your eligibility for benefits based on that information and in accordance with the policy and applicable laws;
- if **we** approve your claim, review **our** decision to approve your claim for benefits as often as is reasonably necessary to determine your continued eligibility for benefits; and
- if **we** deny your claim, explain in writing to **you** the basis for an adverse determination in accordance with the policy as described in the provision entitled "**WHAT NOTIFICATION WILL YOU RECEIVE IF YOUR CLAIM IS DENIED?**"

In the event **we** deny your claim for benefits, in whole or in part, **you** can appeal the decision to **us**. If **you** choose to appeal **our** decision, the process **you** must follow is set forth in the policy provision entitled "**WHAT RECOURSE DO YOU HAVE IF YOUR CLAIM IS DENIED?**" If **you** do not appeal the decision to **us**, then the decision will be Unum's final decision.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If **you** are working while **you** are disabled, the days **you** are disabled will count toward your **elimination period**.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

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

ONCE PAYMENTS BEGIN MUST YOU CONTINUE TO BE UNDER THE REGULAR CARE OF A PHYSICIAN?

You must be under the **regular care** of a **physician** unless **regular care**:

- will not improve your disabling condition(s); or
- will not prevent a worsening of your disabling condition(s).

HOW WILL UNUM CALCULATE YOUR DISABILITY PAYMENT IF YOU ARE TOTALLY DISABLED?

If **you** are **totally disabled** and have an earnings loss of 20% or greater due to the same **disability**, **we** will follow this process to calculate your **monthly payment**.

1. Multiply your **monthly pre-disability earnings** by 60%.

2. The **maximum monthly benefit** is \$3,000.
3. Compare the answer from Item 1 with the **maximum monthly benefit**. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your **gross disability payment** any **benefit reductions**. This is your **monthly payment**.
5. Your **monthly payment** will be adjusted by any **disability earnings** as follows:
 - a. During the first 12 months of payments, while working, add your monthly **disability earnings** to your **gross disability payment**.

If the answer from Item 5a is less than or equal to 100% of your **indexed monthly pre-disability earnings**, Unum will not further reduce your **monthly payment**.

If the answer from Item 5a is more than 100% of your **indexed monthly pre-disability earnings**, Unum will subtract the amount over 100% from your **monthly payment**.

If the answer from Item 5a is more than 100% of your **indexed monthly pre-disability earnings**, Unum will subtract the amount over 100% from your **monthly payment**.

- b. After 12 months of payments, while working, **we** will subtract 50% of your **disability earnings** from your **monthly payment**.

Refer to "**WHAT ARE BENEFIT REDUCTIONS?**" in the **BENEFIT INFORMATION** section for income sources that qualify for **benefit reductions**.

Unum may require **you** to send proof of your monthly **disability earnings** at least quarterly if these records are not available from your **Employer**. **We** will adjust your payment based on your quarterly **disability earnings**.

After the **elimination period**, if **you** are disabled for less than 1 month, **we** will send **you** 1/30 of your payment for each day of **disability**.

WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY PRE-DISABILITY EARNINGS OR MAXIMUM MONTHLY BENEFIT?

The total benefit payable to **you** on a monthly basis (including all benefits provided under this long term disability plan) will not exceed 100% of your **monthly pre-disability earnings** or your **maximum monthly benefit**.

WHAT ARE YOUR MONTHLY PRE-DISABILITY EARNINGS?

"**Monthly Pre-disability Earnings**" means your gross monthly income from your **Employer**, not including shift differential, in effect just prior to your date of **disability**. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your **Employer**.

WHAT WILL WE USE FOR MONTHLY PRE-DISABILITY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

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

WHAT HAPPENS IF YOUR DISABILITY EARNINGS FLUCTUATE WHILE YOU ARE DISABLED?

If your **disability earnings** routinely fluctuate widely from month to month, Unum will average your **disability earnings** over the most recent 3 months to determine if your claim should continue. **We** will not use this average to determine your **monthly payment**.

If Unum averages your **disability earnings**, **we** will not terminate your claim unless the average of your **disability earnings** from the last 3 months exceeds 80% of **indexed monthly pre-disability earnings**.

- 401(k) **plans**
- profit sharing **plans**
- thrift **plans**
- tax sheltered annuities
- stock ownership **plans**
- non-qualified **plans** of deferred compensation
- pension **plans** for partners
- military pension and disability income **plans**
- credit disability insurance
- franchise disability income **plans**
- individual retirement accounts (IRA)
- individual disability income **plans**
- **salary continuation or accumulated sick leave plans**

WHAT IF SUBTRACTING BENEFIT REDUCTIONS RESULTS IN A BENEFIT OF LESS THAN \$100 OR 10% OF YOUR GROSS DISABILITY PAYMENT?

The **monthly payment** will be the greater of:

- \$100; or
- 10% of your **gross disability payment**.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM BENEFIT REDUCTIONS?

Once Unum has subtracted any **benefit reductions** from your **gross disability payment**, Unum will not further reduce your payment due to a cost of living increase from that source.

MUST YOU APPLY FOR BENEFITS LISTED IN THE BENEFIT REDUCTIONS SECTION?

If **you** are entitled to benefits under Item(s) 1, 2, 3 and 4 in the **benefit reductions** section, **you** have an obligation to apply for those benefits.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR BENEFIT REDUCTIONS?

When **we** have both a reasonable, good faith belief that **you** are entitled to benefits under Item(s) 1, 2, 3 and 4, in the **benefit reductions** section and **we** have a means of reasonably estimating the amount payable, **we** will reduce your benefits in accordance with the provision "**HOW WILL UNUM CALCULATE YOUR DISABILITY PAYMENT IF YOU ARE TOTALLY OR PARTIALLY DISABLED?**", if:

- **you** have not applied for such benefits; or
- **you** have applied for such benefits but have not pursued your application with reasonable diligence.

Your Long Term Disability payment will NOT be reduced by the estimated amount if **you** apply for the disability payments under Item(s) 1, 2, 3 and 4, in the **benefit reductions** section and pursue these benefits with reasonable diligence.

Such disorders include, but are not limited to, psychotic, emotional or behavioral disorders. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a **disability**.

Disabilities, due solely to **mental disorders** are limited to a maximum pay period of 24 months.

Unum will continue to send **you** payments beyond the 24 month period if **you** meet one or both of these conditions:

1. If **you** are confined to a **hospital or institution** at the end of the 24 month period, Unum will continue to send **you** payments during your confinement.

If **you** are still disabled when **you** are discharged, Unum will send **you** payments for a recovery period of up to 90 days.

If **you** become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, Unum will send payments during that additional confinement and for one additional recovery period up to 90 more days.

2. In addition to Item 1, if, after the 24 month period for which **you** have received payments, **you** continue to be disabled and subsequently become confined to a **hospital or institution** for at least 14 days in a row, Unum will send payments during the length of the reconfinement.

Unum will not pay beyond the limited benefit period as indicated above, or the **maximum period of payment**, whichever occurs first.

Unum will not apply the **mental disorder** limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR LONG TERM DISABILITY PLAN?

Your long term disability plan does not cover any disabilities caused by or resulting from your:

- intentionally self-inflicted **injuries**.
- active participation in a riot.
- commission of a felony for which **you** have been convicted.
- war, declared or undeclared, or any act of war.
- excluded pre-existing condition.

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

WHAT RECOURSE DO YOU HAVE IF YOUR CLAIM IS DENIED?

You may appeal to **us** for review within 180 days from the receipt of the claim denial. Requests for appeals must be made in writing and should be sent to the address specified in the claim denial. **You** may request access to all relevant documents and will have the opportunity to submit written comments, documents, or other information in support of your appeal.

LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that **you** have died, **we** will pay your **eligible survivor** a lump sum benefit equal to 3 months of your **gross disability payment** if, on the date of your death:

- your **disability** had continued for 180 or more consecutive days; and
- **you** were receiving or were entitled to receive payments under the long term disability plan.

If **you** have no **eligible survivors**, payment will be made to your estate.

However, **we** will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if **you** have been diagnosed as terminally ill.

We will pay **you** a lump sum amount equal to 3 months of your **gross disability payment** if:

- **you** have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to 12 months or less; and
- **you** are receiving **monthly payments**.

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

- **you** must make this election in writing to Unum; and
- your **physician** must certify in writing that **you** have a terminal illness or condition and your life expectancy has been reduced to 12 months or less.

This benefit is available to **you** on a voluntary basis and will only be payable once.

If **you** elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for **you** if:

- **you** are not in **active employment** because of a **sickness** or **injury**; and
- **you** were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.

We will provide **you** with a written Rehabilitation and Return to Work Assistance program developed specifically for **you** with input from **you**, your **physician**, your **Employer**, if needed, and **us**. The plan will start when a written agreement is signed by **you**, Unum and your **Employer**, if needed.

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

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

WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM END?

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

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

STATE REQUIREMENTS

CALIFORNIA CONTACT NOTICE

GENERAL QUESTIONS: If you have any general questions about your insurance, you may contact the Insurance Company by:

CALLING:

1-800-421-0344 (Customer Information Call Center)

-OR-

WRITING TO:

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

COMPLAINTS: If a complaint arises about your insurance, you may contact the Insurance Company by:

CALLING:

(Compliance Center Complaint Line)
Toll free: 1-800-321-3889, Option 2
Direct: 207-575-7568

-OR-

WRITING TO:

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

**WHEN CALLING OR WRITING TO THE INSURANCE COMPANY, PLEASE
PROVIDE YOUR INSURANCE POLICY NUMBER.**

If the Policy or Certificate of Coverage was issued or delivered by an agent or broker, please contact your agent or broker for assistance.

You also can contact the California Department of Insurance. However, the California Department of Insurance should be contacted only after discussions with the Insurance Company or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem.

Department of Insurance
Consumer Communications Bureau
300 South Spring Street - South Tower
Los Angeles, California 90013
In-State Toll Free Hotline Telephone Number: 1-800-927-4357
Local Telephone Number: 213-897-8921
Office Hours: 8:00 a.m. - 5:00 p.m.
www.insurance.ca.gov

This form is for contact information only, and it is not to be considered a condition for the Policy.

OTHER SERVICES

These services are also available from **us** as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE LONG TERM DISABILITY PLAN?

We do provide **you** and your dependents access to a work life assistance program designed to assist **you** with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your **Employer**.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow **you** to perform the substantial and material acts of your usual occupation with your Employer. If **you** return to work in your usual occupation as a result of a modification made by your Employer, Unum will reimburse your Employer for up to the greater of:

- \$1,000; or
- the equivalent of 2 months of your maximum monthly benefit.

The worksite modification benefit will be paid if Unum agrees to the modification in writing prior to its implementation.

This benefit is available to **you** on a one time only basis.

HOW CAN UNUM'S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, **you** must be receiving **monthly payments** from **us**. Unum can provide expert advice regarding your claim and assist **you** with your application or appeal.

Receiving Social Security benefits may enable:

- **you** to receive Medicare after 24 months of disability payments;
- **you** to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist **you** in obtaining Social Security disability benefits by:

GLOSSARY

All Full-Time Members of SEIU Local 1021

ACTIVE EMPLOYMENT means **you** are working for your **Employer** for earnings that are paid regularly and that **you** are performing the **substantial and material acts** of your **usual occupation**. **You** must be working at least 20 hours per week.

Your work site must be:

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

Normal vacation is considered **active employment**.

All Permanent Part-Time Members of SEIU Local 1021

ACTIVE EMPLOYMENT means **you** are working for your **Employer** for earnings that are paid regularly and that **you** are performing the **substantial and material acts** of your **usual occupation**. **You** must be working at least 5 hours per week.

Your work site must be:

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

Normal vacation is considered **active employment**.

BENEFIT REDUCTIONS means amounts paid to **you** in compensation for the same **disability** for which benefits are claimed under this policy. This income will be subtracted from your **gross disability payment**. Refer to "**WHAT ARE BENEFIT REDUCTIONS?**" *your payment*

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

RETIREMENT PLAN means a defined contribution plan or defined benefit plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

SALARY CONTINUATION

LONG TERM DISABILITY/SHORT TERM DISABILITY

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

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

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

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

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

Full effect will be given to your state's civil union, domestic partner and same sex

For residents of Minnesota:

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

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

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

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

For residents of Montana:

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

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

For residents of New Hampshire:

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

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

For residents of North Carolina:

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

For residents of South Carolina:

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

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

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

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

For residents of Vermont:

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

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

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

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

For residents of West Virginia:

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

For residents of Wisconsin:

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

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

APPLICABILITY OF ERISA

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

HOW TO FILE A CLAIM

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

CLAIMS PROCEDURES

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

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

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

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

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

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

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

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

OTHER RIGHTS

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

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

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

These new rights and procedures include:

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

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

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

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

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

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

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

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

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

CORRECTION OF INFORMATION

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

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

COVERAGE DECISIONS

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

CONTACTING US

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

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

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

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unum.com

MK-1883 (06-2020)

NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that the member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows:

Life Insurance, Annuities and Structured Settlement Annuities

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
 - 80% of death benefits but not to exceed \$300,000
 - 80% of cash surrender or withdrawal values but not to exceed \$100,000
- Annuities and Structured Settlement Annuities
 - 80% of present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed 250,000

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

Health Insurance

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016 is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which the insurer became an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans to the extent they are self funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.