Western University of Health Sciences

Your Group Long Term Disability Plan

Policy No. 933869 011

Underwritten by Unum Life Insurance Company of America

1/21/2013
CERTIFICATE OF COVERAGE

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: Western University of Health Sciences
Policy Number: 933869 011
Policyholder’s Original Plan Effective Date: March 1, 2011
    Long Term Disability Plan: March 1, 2011

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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SCHEDULE OF BENEFITS
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):

All Full-Time Employees excluding temporary and seasonal employees in active employment in the United States with the Employer.

Temporary and seasonal workers are excluded from coverage.

DISABILITY COVERED:

Total Disability and Partial Disability

For definition of disability refer to "WHEN ARE YOU TOTALLY DISABLED?" and "WHEN ARE YOU PARTIALLY DISABLED?" in the BENEFIT INFORMATION section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

MAXIMUM MONTHLY BENEFIT:

Option A

60% of monthly pre-disability earnings to a maximum benefit of $4,000 per month.

Your payment will be reduced by benefit reductions and disability earnings. Refer to "WHAT ARE BENEFIT REDUCTIONS?" in the BENEFIT INFORMATION section for income sources that qualify for benefit reductions.

Option B

66.6667% of monthly pre-disability earnings to a maximum benefit of $10,000 per month.

Your payment will be reduced by benefit reductions and disability earnings. Refer to "WHAT ARE BENEFIT REDUCTIONS?" in the BENEFIT INFORMATION section for income sources that qualify for benefit reductions.

ELIMINATION PERIOD:

180 days

This is the period of disability which must be satisfied before you are eligible to receive benefits.

MAXIMUM PERIOD OF PAYMENT (for total disability and partial disability combined):
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<tr>
<th>Age at Disability</th>
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No premium payments are required for your coverage while you are receiving payments under this long term disability plan.

**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: March 1, 2011

PLAN YEAR:
March 1, 2011 to March 1, 2012 and each following March 1 to March 1

POLICY NUMBER: 933869 011

ELIGIBLE GROUP(S):
All Full-Time Employees excluding temporary and seasonal employees in active employment in the United States with the Employer.

Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT:
Employees must be working at least 30 hours per week.

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 March 1, 2011: None

For employees entering an eligible group after March 1, 2011: 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.

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

WHO PAYS FOR THE COVERAGE:

Option A
Your Employer pays the cost of your coverage.

Option B
You and your Employer share the cost of your coverage.
ELIMINATION PERIOD:

180 days

This is the period of disability which must be satisfied before you are eligible to receive benefits.

DISABILITY COVERED:

Total Disability and Partial Disability

For definition of disability refer to "WHEN ARE YOU TOTALLY DISABLED?" and "WHEN ARE YOU PARTIALLY DISABLED?" in the BENEFIT INFORMATION section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

MAXIMUM MONTHLY BENEFIT:

Option A

60% of monthly pre-disability earnings to a maximum benefit of $4,000 per month.

Your payment will be reduced by benefit reductions and disability earnings. Refer to "WHAT ARE BENEFIT REDUCTIONS?" in the BENEFIT INFORMATION section for income sources that qualify for benefit reductions.

Option B

66.6667% of monthly pre-disability earnings to a maximum benefit of $10,000 per month.

Your payment will be reduced by benefit reductions and disability earnings. Refer to "WHAT ARE BENEFIT REDUCTIONS?" in the BENEFIT INFORMATION section for income sources that qualify for benefit reductions.

MAXIMUM PERIOD OF PAYMENT (for total disability and partial disability combined):

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No premium payments are required for your coverage while you are receiving payments under this long term disability plan.
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.

PRE-EXISTING CONDITION:

Benefits are not payable for any disability caused by or resulting from a pre-existing condition, as defined in the policy. To see if your disability excludes you from receiving benefits due to a pre-existing condition, refer to "WHAT IS AN EXCLUDED PRE-EXISTING CONDITION?" in the BENEFIT INFORMATION section.

Some disabilities may not be covered or may have limited coverage under this long term disability plan.

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.
COMPULSORY PROVISIONS

Entire Contract

This policy (the application of the Employer, if any, and the individual applications, if any, of the employees) constitute(s) the entire contract between the parties, and any statement made by the Employer or by any employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Employer, except a fraudulent misstatement, be used at all to void this policy after it has been in force for two years from the date of its issue, nor shall any such statement of any employee eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability (as defined in the policy) commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective.

No change in this policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses

(c) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the Employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at Unum Life Insurance Company of America, 655 North Central Avenue, Suite 900, Glendale, CA 91203, or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.
Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Evidence of Continuing Disability

Once Unum approves your claim you will be asked to provide evidence of continuing disability at reasonable intervals based on your condition. Evidence of continuing disability means documentation of your condition that is sufficient to allow us to determine if you are still disabled. Upon request, you will be asked to provide evidence of continuing disability within 45 days. If evidence is not provided within that period of time, Unum will contact your physician in an effort to obtain the necessary documentation. If you do not submit evidence of continuing disability and Unum is unable to obtain the necessary documentation from your physician or from a reasonably requested examination by a physician of our choice, your payments will end. Upon receipt of evidence of continuing disability, benefit payments will resume subject to the terms of the policy. We will send you a payment for any period for which Unum is liable.

Time of Payment of Claims

Subject to due written proof of loss, all indemnities for loss for which this policy provides payment will be paid (to the insured employee) as they accrue and any balance remaining unpaid at termination of the period of liability will be paid (to the insured employee) immediately upon receipt of due written proof.

Physical Examinations

The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.
Cancellation

The insurer may cancel this policy at any time by written notice delivered to the Employer, or mailed to his last address as shown on the records of the insurer, stating when, not less than 31 days thereafter, such cancellation shall be effective; and after 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 prorata basis the unearned premium paid, if any, and the Employer shall promptly pay on a prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned by the insurer or to be paid by the Employer, any discounts in premium or premium rate actually allowed to the Employer because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the prorata return or payment of premium will be computed upon the basis of the insurer's regular and customary premium or premium rate for the coverage of this policy.) Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

Illegal Occupation or Commission of a Felony

The insurer shall not be liable for any loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal occupation.
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?

All Full-Time Employees excluding temporary and seasonal employees 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 March 1, 2011: None

For employees entering an eligible group after March 1, 2011: 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?

These plans provide different benefit options. When you first become eligible for coverage, you may apply for any option, however, you cannot be covered under more than one option under each plan.

Your Employer pays 100% of the cost of your coverage for Option A. If you don't apply for any other option you will automatically be covered under Option A at 12:01 a.m. on the date you are eligible for coverage.

You and your Employer share the cost of your coverage for any other option. You will be covered at 12:01 a.m. on the date you are eligible for coverage.
If you first become eligible for coverage after the plan effective date, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the date you apply for insurance, if you apply within 31 days after your eligibility date.

WHEN CAN YOU CHANGE YOUR COVERAGE BY CHOOSING ANOTHER OPTION?

You can change your coverage by applying for a different option only during an annual enrollment period or within 31 days of a change in status. You can increase your coverage by one level or decrease your coverage any number of levels.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

A change in coverage due to a change in status will begin at 12:01 a.m. on the later of:

- the date of the change in status, if you apply on or before that date; or
- the date you apply, if you apply within 31 days after the date of the change in status.

Changes in coverage must be consistent with the change in status.

If you end employment and are rehired within the same plan year, you may be insured on your eligibility date for the coverage that you had under the plan when you ended employment. You cannot change your coverage until the next annual enrollment period or change in status.

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

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

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

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

If you are on a leave of absence, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your leave of absence begins.
WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your monthly earnings or due to a plan change requested by your Employer 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.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

In addition, submission of false information in connection with the claim form may also constitute a crime under federal laws. Unum will pursue any appropriate legal remedies in the event of insurance fraud, including prosecuting under federal mail fraud, federal wire fraud, and/or the federal Racketeer Influenced and Corrupt Organizations Act statutes. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

DOES THE POLICY REPLACE OR AFFECT ANY 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.
**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For purposes of the policy, your **Employer** acts on its own behalf as your agent or as Unum's agent for the limited purpose of individualizing certificates and providing contact information at time of claim. Under no other circumstance will your **Employer** be deemed the agent of Unum.
LONG TERM DISABILITY

BENEFIT INFORMATION

WHEN ARE YOU TOTALLY DISABLED?

For the first 30 months, you are totally disabled when you are rendered unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way.

After benefits have been paid for 24 months of disability you are totally disabled when you are:

- rendered unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way; and
- rendered unable to engage with reasonable continuity in another occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity.

Substantial and material acts, as used in the above definitions of disability, means acts that:

- are normally required for the performance of your usual occupation or another occupation; and
- cannot be reasonably omitted or modified.

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

WHEN ARE YOU PARTIALLY DISABLED?

You are partially disabled when you are not totally disabled and you are performing with reasonable continuity one or more of the substantial and material acts necessary to pursue your usual occupation in the usual and customary way, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required.

After benefits have been paid for 24 months you are partially disabled when:

- you are performing with reasonable continuity one or more of the substantial and material acts necessary to pursue your usual occupation in the usual and customary way, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required; or
- you are performing with reasonable continuity one or more of the substantial and material acts necessary to engage in another occupation which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required.

Substantial and material acts, as used in the above definitions of disability, means acts that:
- are normally required for the performance of your usual occupation or another occupation; and
- cannot be reasonably omitted or modified.

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

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

You must be continuously disabled through your elimination period. Unum will treat your disability as continuous if your disability stops for 30 days or less during the elimination period. The days that you are not disabled will not count toward your elimination period.

Your elimination period is 180 days.

This is the period of disability which must be satisfied before you are eligible to receive benefits.

**HOW WILL UNUM DETERMINE YOUR ELIGIBILITY FOR BENEFITS?**

Unum, and not your Employer or plan administrator, has the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits for any claim you make on the policy. We will:

- 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?

OPTION A

If you are totally disabled 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 $4,000.
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.

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

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.

OPTION B

If you are totally disabled we will follow this process to calculate your monthly payment.

1. Multiply your monthly pre-disability earnings by 66.6667%.
2. The maximum monthly benefit is $10,000.
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.

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

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

If you are **partially 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**.

**OPTION A**

1. Multiply your **monthly pre-disability earnings** by 60%.
2. The **maximum monthly benefit** is $4,000.
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**.

   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**.

**OPTION B**

1. Multiply your **monthly pre-disability earnings** by 66.6667%.
2. The **maximum monthly benefit** is $10,000.
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.

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 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 PARTIALLY 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.

We will not pay you for any month during which disability earnings exceed the amount allowable under the long term disability plan.

WHAT ARE BENEFIT REDUCTIONS?

Unum will only subtract benefit reductions which are paid or to which you are entitled, in accordance with the provision "WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR BENEFIT REDUCTIONS?", as a result of the same disability and inability to work as that claimed under the policy. Unum will subtract from your gross disability payment the following benefit reductions:

1. The amount that you receive or are entitled to receive as a temporary disability benefit under a workers' compensation law.

2. The amount that you receive or are entitled to receive under an occupational disease law or any other act or law with similar intent, other than workers' compensation.

3. The amount that you receive or are entitled to receive as disability income payments under any state compulsory benefit act or law.

4. The amount that you receive as disability income payments under any governmental retirement system as a result of your job with your Employer.

5. The amount that you, your dependent spouse and children receive or are entitled to receive as disability payments because of your disability under:
   - the United States Social Security Act.
   - the Canada Pensions Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

6. The amount that you receive as disability payments under your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

We will not reduce your benefit by amounts rolled over or transferred to any eligible retirement plan.
7. The amount that you receive as disability payments under Title 46, United States Code Section 688 (The Jones Act).

If you receive a lump sum payment from any benefit reductions, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.

WHAT ARE NOT BENEFIT REDUCTIONS?

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- 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 $50 OR 10% OF YOUR GROSS DISABILITY PAYMENT?

The monthly payment will be the greater of:

- $50; 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 5 in the benefit reductions section, you have an obligation to apply for those benefits.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR BENEFIT REDUCTIONS?
HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the maximum period of payment. Your maximum period of payment for total disability and partial disability combined is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 60</td>
<td>To age 65, but not less than 60 months</td>
</tr>
<tr>
<td>Age 60</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 61</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 62</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>30 months</td>
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<tr>
<td>Age 65</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>21 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>18 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>15 months</td>
</tr>
<tr>
<td>Age 69 and over</td>
<td>12 months</td>
</tr>
</tbody>
</table>

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the long term disability plan;
- when you fail to comply with the Evidence of Continuing Disability section;
- the date you fail to submit to any reasonable request to be examined by a physician of our choice without just cause;
- the date the most recent 3 month average of your disability earnings exceed 80% of your monthly pre-disability earnings if you are partially disabled;
- the date you die.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud;
- any error Unum makes in processing a claim; and
- your receipt of funds that qualify for benefit reductions.

You must reimburse us in full. We will work with you to determine an appropriate method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.
WHAT IS THE LIMITED BENEFIT PERIOD FOR MENTAL DISORDERS?

MENTAL DISORDER means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. 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 PRE-EXISTING CONDITIONS ARE EXCLUDED?**

You have an excluded pre-existing condition if:

- you received medical treatment, care or services for a diagnosed condition, or took prescribed drugs or prescribed medicines for that condition, in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

No claim for disability commencing after 2 years from your effective date of coverage shall be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to your effective date of coverage.

**WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?**

If you have a recurrent disability, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- your prior claim ended when you returned to work for your Employer and your earnings from your Employer exceeded 80% of your monthly pre-disability earnings;
- you were continuously insured under the long term disability plan for the period between your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months of the end of your prior claim.

Your recurrent disability will be subject to the same terms of this long term disability plan as your prior claim.
Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions.

If you are no longer covered under the policy and you receive payments under any other group long term disability plan offered through your current Employer, this provision will no longer apply.

**WHAT NOTIFICATION WILL YOU RECEIVE IF YOUR CLAIM IS DENIED?**

If your claim is denied, in full or in part, Unum will notify you in writing. This notification will include:

- the specific reason for the denial;
- the policy provisions on which the denial is based;
- a description of any additional information necessary to complete the claim and an explanation of why that information is necessary; and
- a description of the policy's procedures and applicable time limits for appeal.

**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.
WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained in force; or
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum period of payment under the plan; or
2. the date benefits would have ended under the prior plan if it had remained in force.
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:
Deborah J. Jewett, Manager, Customer Relations
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.

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’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:

- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.
GLOSSARY

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 30 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.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year.

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?" in the BENEFIT INFORMATION section for income sources that qualify for benefit reductions.

CHANGE IN STATUS means a change in status as defined in the regulations under Internal Revenue Code section 125, unless your Employer's cafeteria plan document or human resource policy contains more restrictive provisions. In that event, your Employer may restrict the situations where you can change your coverage.

DISABILITY means total disability or partial disability due to sickness or injury.

DISABILITY EARNINGS means the earnings which you receive for work performed while you are disabled and working for your Employer or earnings received from another employer if you became employed after your disability began.

ELIGIBLE SURVIVOR means your spouse or registered domestic partner, if living; otherwise your children equally.

ELIMINATION PERIOD means a period of total disability and/or partial disability which must be satisfied before you are eligible to receive benefits from Unum.

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

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

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

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made without cancellation or modification of the policy.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts benefit reductions and disability earnings.
HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INDEXED MONTHLY PRE-DISABILITY EARNINGS means your monthly pre-disability earnings adjusted on each anniversary of benefit payments by the current annual percentage increase in the Consumer Price Index. Your indexed monthly pre-disability earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working.

INJURY means physical harm or damage to the body. Injury which occurs before you are covered under the policy will be treated as a sickness.

INSURED means any person covered under the policy.

LAW, PLAN OR ACT means the original enactments of the law, plan or act and all amendments.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

MAXIMUM MONTHLY BENEFIT means the total benefit amount for which an employee is eligible under this long term disability plan subject to the terms of the policy.

MAXIMUM PERIOD OF PAYMENT (for total disability and partial disability combined) means the longest period of time Unum will make payments to you.

MENTAL DISORDER means a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. 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.

MONTHLY PRE-DISABILITY EARNINGS means your gross monthly income from your Employer as defined in this long term disability plan.

MONTHLY PAYMENT means your payment after any benefit reductions have been subtracted from your gross disability payment.
PARTIALLY DISABLED means you are not totally disabled and you are performing with reasonable continuity one or more of the substantial and material acts necessary to pursue your usual occupation in the usual and customary way, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required.

After benefits have been paid for 24 months you are partially disabled when:

- you are performing with reasonable continuity one or more of the substantial and material acts necessary to pursue your usual occupation in the usual and customary way, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required; or
- you are performing with reasonable continuity one or more of the substantial and material acts necessary to engage in another occupation which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity, but you are unable to perform all of the substantial and material acts or you are unable to perform them for as long as normally required.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction and is performing tasks that are within the limits of his or her medical license; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

POLICYHOLDER means the Western University of Health Sciences, to whom the policy is issued.

PRE-EXISTING CONDITION means a diagnosed condition for which you received medical treatment, care or services, or took prescribed drugs or prescribed medicines for that condition.

RECURRENT DISABILITY means a disability which reoccurs after your disability ends and is due to the same cause(s) as your prior disability for which Unum made a disability payment.

REGISTERED DOMESTIC PARTNER means the person named in your declaration of domestic partnership that has been filed with the Secretary of State of California.

REGULAR CARE means:

- 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 OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your monthly pre-disability earnings, after you become disabled as defined by the policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins.

SICKNESS means an illness or disease.

TOTALLY DISABLED means, for the first 30 months, you are rendered unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way.

After benefits have been paid for 24 months of disability you are totally disabled when you are:

- rendered unable to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation in the usual and customary way; and
- rendered unable to engage with reasonable continuity in another occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity.

USUAL OCCUPATION means the substantial and material acts you are routinely performing for your Employer when your disability begins.

WAITING PERIOD means the continuous period of time that you must be in active employment in an eligible group before you are eligible for coverage under the policy.


YOU means an employee who is eligible for Unum coverage.
ERISA

Additional Summary Plan Description Information

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. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
Western University of Health Sciences Plan

Name and Address of Employer:
Western University of Health Sciences
309 E. Second Street
Pomona, California
91766-1854

Plan Identification Number:
  a. Employer IRS Identification #: 95-3127273
  b. Plan #: 501

Type of Welfare Plan:
Disability

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

ERISA Plan Year Ends:
March 31

Plan Administrator, Name, Address, and Telephone Number:
Western University of Health Sciences
309 E. Second Street
Pomona, California
91766-1854
(909) 469-5371

Western University of Health Sciences is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Western University of Health Sciences
309 E. Second Street
Pomona, California
91766-1854
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 933869 011. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER'S RIGHT TO AMEND THE PLAN**

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

**EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE**

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

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify the policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy; fewer than 25 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pays the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- 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; or
- the Policyholder fails to pay any portion of the premium within the 31 day grace period.

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

Unum also reserves the right to set a participation requirement for each coverage option under a plan and to cancel an option if the participation requirement is not met.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or a plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. Unum will not cancel the policy or a plan during a period for which the Policyholder has paid premium.

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

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

HOW TO FILE A CLAIM

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

CLAIMS PROCEDURES

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

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

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

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

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

**APPEAL PROCEDURES**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker’s subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;

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

- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

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

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

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of 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.

DELEGATION OF AUTHORITY

The Plan, acting through the Plan Administrator, delegates to Unum and its affiliate Unum Group 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 or entities.

HOW UNUM DETERMINES YOUR ELIGIBILITY FOR BENEFITS

Unum, and not your Employer or Plan Administrator, has the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits for any claim you make on the policy. We will:

- 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.

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. If you do not appeal the decision to us, then the decision will be Unum's final decision.
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 and 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 April 1, 2011, is $470,125. 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.
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 1607.02(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  California Department of Insurance
P.O. Box 16860  Consumer Communications Bureau
Beverly Hills, CA 90209-3319  Los Angeles, CA 90013
(323) 782-0182  (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.