



# UnitedHealthcare®

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## **SHORT TERM DISABILITY INSURANCE**

### **CERTIFICATE OF COVERAGE**

**For**

**ENNOVA LLC**

GROUP NUMBER: 1788761

EFFECTIVE DATE: June 1, 2026

STD PLAN: STDF20038

Offered and Underwritten by  
UnitedHealthcare Insurance Company

## **STATE MANDATED DISABILITY REQUIREMENTS**

**The following states legislatively mandate that certain employers provide state disability benefits for employees working in the state:**

**California**

**Hawaii**

**New Jersey**

**New York**

**Rhode Island**

**Puerto Rico**

**The disability coverage available under this plan is not intended to replace any state mandated disability coverage. The disability benefits provided in this Certificate of Coverage will be reduced by any benefits received under a state mandated disability plan.**

**UnitedHealthcare Insurance Company**

**Home Office: 185 Asylum Street, Hartford, Connecticut 06103-3408**

**Administrative Office: 9900 Bren Road East, Minnetonka, MN 55343**

**www.uhc.com**

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**CERTIFICATE OF COVERAGE**

**Policyholder:** ENNOVA LLC

**Policy Effective Date:** June 1, 2026

**Policy Anniversary Date:** June 1 of each year

**Policy Number:** 1788761

**Beneficiary:** As on file with the Administrator

UnitedHealthcare Insurance Company (We, Our, Us or the Company), has issued the Policy to the Policyholder shown above.

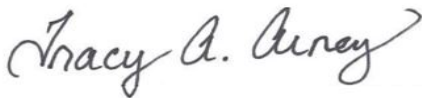
This Certificate replaces any other Certificate previously issued and is incorporated in and made part of the Policy on the Effective Date shown in the Policy's Incorporation Provision.

**Read Your Certificate Carefully.** If You have questions or need information about Your insurance, call 1-866-615-8727.

**Capitalization in this Certificate:** Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term or a specific provision herein.

**Time Periods:** All periods begin and end at 12:01 A.M., standard time, at the Policyholder's address.

Signed for the Company by:



Tracey A. Arney, Secretary



Robert Hunter, President

**Insurance Products: Group Short Term Disability Insurance**

**Non-Participating (no dividends paid)**

### **Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

#### **UnitedHealthcare Insurance Company**

To get information or file a complaint with your insurance company:

**Call: UnitedHealthcare Insurance Company**

**Toll-free: 1-866-615-8727**

Mail: United HealthCare Insurance Company Administrative Offices

9900 Bren Road East, Minnetonka. MN 55343

#### **The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Email: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

### **¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

#### **UnitedHealthcare Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a: UnitedHealthcare Insurance Company**

**Teléfono gratuito: 1-800-405-9090**

Dirección postal: United HealthCare Insurance Company Administrative Offices

9900 Bren Road East, Minnetonka. MN 55343

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: [www.tdi.texas.gov](http://www.tdi.texas.gov)

Correo electrónico: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

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## SCHEDULE OF BENEFITS

**Policyholder:** ENNOVA LLC

**Description of Eligible Class(es):** Employees of the Policyholder who are Actively at Work and who are Full-time Employees working at least 30 hours per week.

**Employee Waiting Period:** The first day of the month following the date the Employee begins continuous employment with the Policyholder.

**Rehire Period:** Within 12 months of the date Your insurance ended.

### Insurance Funding Information:

#### Non-Contributory Insurance:

- Short Term Disability Insurance – Your Employer pays the entire premium.

Short Term Disability Premium contributions must continue while You are receiving Short Term Disability payments.

**Premium Rate Change:** Your premium may change on any premium due date if rates for Your Class are changed under the Policy.

### Your Benefits and Benefit Amounts

| <u>Your Insurance Benefits</u>                   | <u>Benefit Information</u>                                                        |                                    |
|--------------------------------------------------|-----------------------------------------------------------------------------------|------------------------------------|
| <b>Short Term Disability Benefit</b>             | <b>Benefit Percentage of Short Term Disability Pre-Disability Weekly Earnings</b> | <b>Base Plan: 60%</b>              |
|                                                  | <b>Maximum Weekly Benefit Amount</b>                                              | \$750 per week                     |
|                                                  | <b>Minimum Weekly Benefit Amount</b>                                              | \$25 per week                      |
|                                                  | <b>Maximum Benefit Duration</b>                                                   | 13 weeks                           |
|                                                  | <b>Elimination Period</b>                                                         | Injury: 0 days<br>Sickness: 7 days |
|                                                  | Benefits are issued on a non-occupational basis.                                  |                                    |
| <u>Additional Short Term Disability Benefits</u> | <u>Benefit Information</u>                                                        |                                    |
| Short Term Disability                            | Included                                                                          |                                    |

## SCHEDULE

|                                                 |                                                                                                           |
|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Rehabilitation Benefit                          |                                                                                                           |
| Short Term Disability Lump Sum Survivor Benefit | <p>Benefit Amount: 3 weeks of weekly Gross Disability Payments</p> <p>Maximum Benefit Amount: \$3,000</p> |



## DEFINITIONS

**Active Work or Actively at Work** means You are performing all the regular duties of Your occupation:

1. at Your usual place of employment or any other business location where You are required to travel;
2. for the entire normal workday; and
3. for at least the minimum number of hours per week, as shown in the Description of Eligible Class(es) in the Schedule of Benefits.

You or Your Employer must provide Us satisfactory documentation that You are Actively at Work in accordance with the Proof of Claim provision.

Unless You are disabled or terminate Your employment on the prior workday or on a day of absence, We will consider You to be Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an approved or emergency leave of absence (except medical leave).

**Certificate or Certificate of Coverage** means this document, which describes the benefits, terms, conditions, limitations and exclusions provided by the Policy. If there is a conflict between the Policy and the Certificate, the Policy will control.

**Change in Status** means any of the following changes:

1. a change in marital status (marriage, divorce, legal separation, annulment);
2. a change in the number of Your dependents for tax purposes (birth, legal adoption of a child, placement of a child for adoption, or death of a dependent);
3. certain changes in employment status that affect Your benefit eligibility, such as termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (between full-time and part-time work, decrease or increase in hours);
4. a significant increase in the cost of insurance or a significant reduction of insurance under Your other insurance or Your spouse's insurance; or
5. the addition, elimination, or significant reduction, of an insurance option.

**Contributory Insurance** means insurance which You have elected and for which You have agreed to make the required premium contributions.

**Covered Person** means the Employee insured under the Policy and to whom this Certificate is issued.

**Disability Earnings** means the earnings You receive while Disabled and working.

**Elimination Period** means the length of time You must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Your Disability.

**Employee** means a person who works for the Employer on a regular basis:

1. in the normal business of the Employer;
2. is paid for services by the Employer;
3. who resides in the United States, its territories and protectorates; and
4. is Actively at Work for the Employer, or any subsidiary or affiliate insured under the Policy.

Employee does not include temporary, leased or seasonal Employees.

## DEFINITIONS

No director or officer of the Employer will be considered an Employee unless they work directly for and receive a salary, from the Employer.

**Employer** means the Policyholder and:

1. may also include any division, subsidiary, or affiliated company named in the Schedule of Benefits; and
2. does not include any employer who is not the Policyholder.

**Essential Duty/Duties** means a duty that:

1. is substantial, not incidental;
2. is fundamental or inherent to Your Occupation; and
3. cannot be reasonably omitted or changed.

We will not consider working more than 40 hours per week an Essential Duty if Your Occupation requires that You work in excess of 40 hours per week, on average.

**Evidence of Insurability** means specific information about You which You provide to Us when applying for insurance. That information includes:

1. a completed and signed application;
2. a medical examination if requested;
3. an Attending Physician's Statement if requested; and
4. any additional information We may require.

**Gross Disability Payment** means the payment amount before We subtract Other Income Benefits and Disability Earnings.

**Hospital** means an institution which:

1. operates pursuant to law;
2. primarily and continuously provides medical care and Treatment of sick and injured persons on an inpatient basis;
3. operates facilities for medical and surgical diagnosis and Treatment by or under the supervision of a staff of legally qualified Physicians;
4. provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.s);
5. is located within the United States or its territories and protectorates and is approved by the Joint Commission on the Accreditation of Hospitals (JCAH); and
6. operates primarily for the Treatment for Substance Abuse on an inpatient basis.

Hospital does not mean any institution or part thereof which is used primarily as:

1. a nursing home, convalescent home or skilled nursing facility;
2. a rehabilitation center;
3. a place for rest, custodial care, or for the aged; or
4. a clinic.

**Hospital Confined or Hospital Confinement** means You are admitted as an inpatient in a Hospital for a period of at least 24 hours for the Sickness or Injury that resulted in Your Disability. Surgery as an outpatient, or in ambulatory surgical facility, will not be considered Hospital Confined.

**House Arrest** means any restriction placed on Your movement outside of Your home by a court of competent jurisdiction. We may require proof of compliance with such restriction.

## DEFINITIONS

**Immediate Family** means Your spouse or domestic partner, child, parent or sibling; or Your spouse's or domestic partner's child, parent or sibling.

**Injury** means bodily injury, which occurs as the result of an accident while insured under the Policy. The Injury must be the direct cause of the loss, independent of disease, bodily infirmity or any other cause.

**Intoxicated or Intoxication** means being under the influence as defined by applicable state law as determined by:

1. the blood alcohol content; or
2. the results of other means of testing blood alcohol content or the content of other substances.

**Mental Illness** means any Sickness, disease or disorder, which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental Illness includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to:

1. bipolar disorder;
2. depression and depressive disorders;
3. psychoses;
4. mood disorders;
5. manic-depressive illness;
6. anxiety disorders;
7. stress disorders including post-traumatic stress disorders;
8. somatoform disorders;
9. factitious disorders;
10. eating disorders;
11. adjustment disorders; and
12. personality disorders.

For purposes of the Policy, Mental Illness does not include coma (unless a consequence of Substance Abuse), intellectually incapacitated or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

**Non-Contributory Insurance** means insurance which You do not have to elect nor make any premium contributions.

**Occupational Sickness or Injury** means a Sickness or Injury which is paid or payable by any workers' compensation law, occupational disease law or similar law.

**Other Income Benefits** means:

1. any benefits and awards You receive or are eligible to receive under:
  - a. Workers' Compensation Law;
  - b. occupational disease law; or
  - c. any other similar act or law;
2. any disability income benefits You receive or are eligible to receive under:

## DEFINITIONS

- a. any compulsory benefit act or law;
  - b. any other group insurance policy with Your Employer or with an association;
  - c. any other group insurance policy with another employer under which You become insured while You are Disabled under the Policy; or
  - d. any governmental retirement system as the result of Your job with Your Employer;
3. any benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, the Jones Act, and any other similar plan or Act. Benefits include:
  - a. disability benefits You are eligible to receive and any disability benefits Your spouse or Your children receive or are eligible to receive as a result of Your Disability; and
  - b. retirement benefits You receive under a Retirement Plan and any retirement benefits Your spouse or Your children receive as a result of Your receipt of retirement benefits.
4. any income You receive from Your Employer as a result of any accumulated sick time, salary continuation, paid time off or vacation pay;
5. any benefits from Your Employer's Retirement Plan, the Public Employees Retirement System and the State Teachers Retirement System You:
  - a. receive as disability benefits;
  - b. voluntarily choose to receive as retirement benefits; or
  - c. receive as retirement benefits once You reach the greater of age 62 or normal retirement age, as defined in Your Employer's Retirement Plan;
6. any benefits for loss of time or lost wages You receive from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy;
7. any amount You receive under any unemployment compensation law; (We will not deduct unemployment compensation as an Other Income Benefit for Short Term Disability if such insurance is issued on a non-occupational basis;) and
8. any amounts You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

Other Income Benefits will not include payments or income from:

1. 401(k) plans;
2. profit sharing plans;
3. thrift plans;
4. tax sheltered annuities;
5. stock ownership plans;
6. non-qualified plans of deferred compensation;
7. Pension Plans for partners;
8. military pension and military disability income plans;
9. credit disability insurance;
10. franchise disability income plans;
11. a Retirement Plan from another employer;
12. Individual Retirement Accounts (IRA); and
13. individual disability income plans.

## DEFINITIONS

**Pension Plan** means a plan that provides retirement benefits and which is not wholly funded by Your contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given; and
3. practicing within the scope of that license.

The term Physician does not include You or members of Your Immediate Family.

**Policy** means the legal contract between the Policyholder and Us. It may be changed or discontinued without Your or Your Beneficiary's consent. The Policy may be inspected at the office of the Policyholder.

**Prior Group Plan** means the group insurance policy carried by the Employer on the day before the Policy's Effective Date.

**Regular Care** means You visit a Physician:

1. as often as is medically required to effectively manage and treat Your disabling condition; and
2. who provides Treatment and care for Your condition according to:
  - a. generally accepted medical standards; and
  - b. the Physician's specialty or experience.

**Retirement Plan** means an eligible Retirement Plan as defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition. Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to You, We consider Employee and Employer contributions to be distributed at the same time throughout Your lifetime.

Retirement benefits under a Retirement Plan are benefits that are paid based on Your Employer's contribution to the Retirement Plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit. Disability benefits under a Retirement Plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

**Short Term Disability Pre-Disability Weekly Earnings** means the weekly earnings You received from Your Employer on the day before the date You become Disabled. Short Term Disability Pre-Disability Weekly Earnings also includes commissions, averaged over the lesser of the most recent 24 month period of Your period of employment. It does not include bonuses, overtime pay, and other extra compensation.

If You become Disabled while Your insurance is being continued under Continuation of Insurance, We will calculate Your benefit using Your Short Term Disability Pre-Disability Weekly Earnings from Your Employer in effect just prior to the date Your continuation began.

**Sickness** means an illness, disease, pregnancy or complication of pregnancy.

**Substance Abuse** means alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician.

**Treatment** means any consultation, advice, tests, attendance or observation, supplies or equipment, including prescriptions or the use of prescription drugs or medications.

**Vocational Rehabilitation Consultant** means someone who specializes in the areas of:

1. vocational rehabilitation;

## DEFINITIONS

2. vocational and occupational availability in the current labor market; and
3. skills that are needed to perform specific occupations.

The term Vocational Rehabilitation Consultant does not include You or members of Your Immediate Family.

**We, Our, Us or the Company** means UnitedHealthcare Insurance Company, and its administrators and representatives.

**Weekly Payment** means the payment amount after We subtract any Other Income Benefits. The Weekly Payment will never be less than the Minimum Weekly Benefit Amount.

**You or Your** means the Employee insured under the Policy and to whom this Certificate is issued.

**Your Occupation** means Your occupation, which You are routinely performing when Your Disability occurs, as it is recognized in the national economy. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

The loss of a professional or occupational license or certification, work permit, or visa does not, in itself, mean You are Disabled. Additionally, economic factors, such as recession, job obsolescence, pay-cuts and job sharing will not be considered in determining if You are Disabled.

## **ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS**

**Covered Person Eligibility:** You will become eligible for insurance on the latest of:

1. the Effective Date of the Policy;
2. the date You complete the required Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include Your Class; or
4. the date You enter a Class eligible for insurance, as shown in the Schedule of Benefits.

### **Enrolling for Your Insurance Under the Policy:**

For Non-Contributory Insurance: Your Employer will automatically enroll You.

For Contributory Insurance: You must complete Your Employer's enrollment process. If You do not enroll for Your insurance within 31 days after becoming eligible under the Policy, You may enroll within 31 days of the date You have a Change in Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

### **Covered Person Effective Date of Insurance:**

If Your insurance is Non-Contributory and Evidence of Insurability is not required, Your insurance will start on the date You become eligible for insurance, regardless of when You apply.

If Your insurance is Contributory, and Evidence of Insurability is not required, Your insurance will start on the latest of:

1. the date You become eligible, if You enroll on or before that date; or
2. the date You enroll, if You do so within 31 days from the date You are eligible or have a Change in Status.

Any insurance for which Evidence of Insurability is required, will become effective on the later of:

1. the date You become eligible; or
2. the date We approve Your Evidence of Insurability, as stated in Your notification.

### **Deferred Effective Date:**

If You are not Actively at Work on the date Your insurance is scheduled to take effect, it will take effect on the date You return to Active Work. If Your insurance is scheduled to take effect on a non-working day, Your Actively at Work status will be based on the last working day before the scheduled Effective Date of Your insurance.

All Effective Dates of insurance are subject to the Deferred Effective Date provision.

### **Evidence of Insurability Requirements:**

Evidence of Insurability is required, at Your expense, for Your Contributory Insurance if You:

1. apply more than 31 days after the date You:
  - a. first became eligible for insurance; or
  - b. have a Change in Status;
2. apply after You had previously terminated Your insurance while in an Eligible Class, unless You apply due to a Change in Status; or
3. apply for insurance and Your Employer has less than 2 Employees.

You must use forms provided by Us when providing Evidence of Insurability.

Evidence of Insurability must be approved by Us in writing for insurance to become effective.

**Continuity of Your Insurance Under a Prior Group Plan:**

We will maintain the continuity of Your Insurance under a Prior Group Plan for Your initial insurance under the Policy as follows:

1. **If You are not Actively at Work on the Policy's Effective Date:** We will waive the Deferred Effective Date requirement for Your initial insurance under the Policy if You were insured under the Prior Group Plan, and on the Policy's Effective Date, You:
  - a. are not Actively at Work; and
  - b. are eligible for insurance except for meeting the Actively at Work requirement.
2. **If You are Disabled Due to a Pre-Existing Condition:** If Your Disability is due to a Pre-Existing Condition, You may be eligible for payments under the Policy if You:
  - a. were insured by a Prior Group Plan;
  - b. are Actively at Work; and
  - c. have been continuously insured under the Policy from the effective date of Your insurance through the date of Your Disability.

We may require proof that You were insured under the Prior Group Plan.

We will apply the time You were continuously insured under both a Prior Group Plan and the Policy to satisfy any Pre-Existing Condition Exclusion under the Policy. If You do not satisfy either policy's pre-existing condition exclusion provision, We will not make any payment.

We will determine Our payments using the provisions of the Policy; however the applicable maximum benefit payment will not be more than the applicable maximum benefit payment of a Prior Group Plan.

Your benefit payments will end on the earlier of the following:

1. the end of the applicable Maximum Benefit Duration under the Policy; or
2. the date benefits would have ended under a Prior Group Plan, if that policy had stayed in effect.

After the Policy's Effective Date, the Pre-existing Conditions Exclusion will apply to the amount of a benefit increase which results from:

1. a change from a Prior Group Plan to the Policy;
2. a change in benefit options;
3. a change of class; or
4. a change in the Policy.

**Covered Person Termination of Insurance:** Your insurance will terminate on the earliest of the following dates:

1. the last day of the period the required premium is due but not paid, subject to the Grace Period provision;
2. the date You cease to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date You are no longer Actively at Work for any other reason, unless insurance is continued in accordance with the Continuation of Insurance Provisions.

If You are Disabled and You cease to be Actively at Work, Your insurance will be continued:

1. while You remain Disabled; and
2. until the end of the period for which You are entitled to receive Benefits.



## ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

After benefit payments have ceased, Your insurance will be reinstated, provided:

1. You return to work for one full day as a full-time Actively at Work Employee in an eligible class;
2. the Policy remains in force; and
3. the premiums for Your insurance were paid during Your Disability (if required) and continue to be paid.

**Grace Period:** A Grace Period of 31 days will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the insurance will continue in effect provided the premium is paid by the Policyholder before the end of the Grace Period. The Grace Period will not continue the insurance beyond a date shown in the Covered Person Termination of Insurance provision.

## CONTINUATION AND REINSTATEMENT PROVISIONS

### Continuation of Insurance:

Insurance under the Policy may be continued beyond a date stated in the Covered Person Termination of Insurance provision, according to the Continuation Provisions. The amount of continued insurance applicable will be the amount of insurance in effect on the date immediately before insurance would otherwise have ended and is subject to payment of premium. Insurance that is continued:

1. may be continued up to the maximum time shown in the applicable provision(s); and
2. terminates if the Policy terminates.

The amount of insurance will not increase while insurance is continued under one or more of the following provisions.

#### Continuation Provisions:

1. leaves of absence must be approved in writing by Your Employer; and
2. when combined, will not extend longer than 3 months from the date You were last Actively at Work.

All other terms of Your insurance under the Policy remain unchanged.

If Your insurance does not continue during an approved Continuation Provision, then when You return to Active Work:

1. You will not have to meet a new Employee Waiting Period including a waiting period for insurance of a Pre-Existing Condition, if applicable; and
2. You will not have to give Us Evidence of Insurability to reinstate the insurance You had in effect before Your continuation began.

### Continuation Provisions:

**Family and Medical Leave:** If You are granted a leave of absence, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your insurance may be continued for up to 12 weeks following the date Your leave commenced. Continuation may be a longer period if required by any other applicable state or local law. If the leave ends prior to the agreed upon date, the continuation will cease immediately.

**Leave of Absence:** If You are on an approved non-medical leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your insurance may be continued until the end of the month following the month You stopped being Actively at Work, with respect to a non-medical leave of absence.

Continuation may be a longer period if required by law.

**Military Leave of Absence:** If You enter active military service and are granted a military leave of absence, Your insurance may be continued for up to 12 weeks from the date You stopped being Actively at Work or a longer period if required by law.

**Status Change:** If You are an Employee, but no longer in an Eligible Class due to a reduction in the number of scheduled hours You work, Your insurance may be continued for 90 consecutive days after the date Your scheduled hours were reduced.

### Reinstatement: If:

1. Your insurance ends because You are no longer employed by the Employer or no longer in Your Eligible Class; and
2. You are rehired or return to Your Eligible Class within the time period shown on the Schedule of Benefits;

## CONTINUATION AND REINSTATEMENT PROVISIONS

then Your insurance may be reinstated, provided You request such reinstatement within 30 days of the date You return to work or to an Eligible Class.

The reinstated insurance will be the lesser of the:

1. insurance amounts in force on the date insurance ended; or
2. amount of insurance in Your new Eligible Class.

The reinstated insurance will:

1. not be subject to any Eligibility Waiting Period or Evidence of Insurability; and
2. be subject to all the other terms and provisions of the Policy.

We will credit any amount of time You were previously insured under the Policy toward the satisfaction of time limits under the Contestability provision of the Policy.

## SHORT TERM DISABILITY BENEFIT

**Short Term Disability Benefit:** If You become Disabled while insured under the Policy due to a Sickness or Injury, We will make Weekly Payments to You, provided You:

1. are Disabled throughout the Elimination Period;
2. remain Disabled beyond the Elimination Period; and
3. submit Proof of Claim to Us.

**Weekly Payments:**

1. begin on the first day after the Elimination Period; and
2. will continue until terminated as described in the Termination of Benefits provision.

The Elimination Period is shown in the Schedule of Benefits.

**Disabled or Disability** means You are not Actively at Work and:

1. You are unable to perform some or all of the Essential Duties of Your Occupation due to Sickness or Injury;
2. Your Disability Earnings are 80% or less than Your Short Term Disability Pre-Disability Weekly Earnings, as applicable solely due to the same Sickness or Injury; and
3. You are under the Regular Care of a Physician.

**Benefit Calculation - Disabled and Working:** If You are Disabled and working, and earning between 20% and 80% of Your Short Term Disability Pre-Disability Weekly Earnings, Your Weekly Payment will be calculated as follows:

Step 1. Multiply Your Short Term Disability Pre-Disability Weekly Earnings by the Benefit Percentage.

Step 2. From 100% of Your Short Term Disability Pre-Disability Weekly Earnings, subtract:

- a. Other Income Benefits; and
- b. any income You earn or receive from any form of employment.

Step 3. Compare the results in Step 1 and Step 2 with Your Maximum Weekly Benefit Amount.

The least amount from Steps 1, 2 and 3 is Your Weekly Payment, which will not exceed the Maximum Weekly Benefit Amount.

After the Elimination Period, if You are Disabled for a portion of a week, We will pro-rate Your Weekly Payment for each day of Disability.

The Benefit Percentage and Maximum Weekly Benefit Amount are shown in the Schedule of Benefits.

**Benefit Calculation - Disabled and Not Working or Disabled and Working and Earning Less Than 20% of Your Short Term Disability Pre-Disability Earnings:** Your Weekly Payment will be calculated as follows:

Step 1. Multiply Your Short Term Disability Pre-Disability Weekly Earnings by the Benefit Percentage.

Step 2. Compare the result in Step 1 with the Maximum Weekly Benefit Amount.

Step 3. The lesser of the results in Step 1 and Step 2 is Your weekly Gross Disability Payment.

Step 4. Subtract any Other Income Benefit amounts from Your weekly Gross Disability Payment as determined in Step 3.

The result is Your Weekly Payment, which will not exceed the Maximum Weekly Benefit Amount.

## SHORT TERM DISABILITY BENEFIT

**Effect of Other Income Benefits on Payment:** We will subtract Other Income Benefits from Your Gross Disability Payment. If subtracting Other Income Benefits results in a zero benefit, Your Weekly Payment will be the Minimum Weekly Benefit Amount shown in the Schedule of Benefits. However, the Minimum Weekly Benefit Amount may be applied toward an outstanding overpayment.

Other Income Benefits must be payable as a result of the same Disability for which You are receiving a Weekly Payment, except for retirement benefits.

We will not reduce Your Weekly Payment by:

1. Your contributions to Your Employer's Retirement Plan;
2. amounts Your Employer rolls over or transfers to an eligible Retirement Plan; or
3. Social Security retirement benefits You were receiving before Your Disability began, if Your Disability began after Your 70th birthday.

If You receive any Other Income Benefits in a lump sum payment, We will pro-rate the lump sum benefit payment on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of Your Maximum Benefit Duration.

**Estimating Amounts of Other Income Benefits:** We have the right to estimate the amount of benefits You may be eligible to receive from Other Income Benefits. We can reduce Your Weekly Payment by the estimated amount if:

1. You have not been awarded but have not been denied such benefits;
2. You have been denied such benefits and the denial is being appealed; or
3. You are reapplying for such benefits.

We will not reduce Your Weekly Payment by the estimated amount if:

1. You apply or reapply for the benefits and appeal Your denial through all of the administrative levels We have determined are necessary; or
2. You sign Our reimbursement agreement form stating that You promise to pay Us any overpayment caused by an award.

If We reduce Your Weekly Payment by an estimated amount:

1. We will adjust Your Weekly Payment when You provide proof of the amount awarded; or
2. We will issue a lump sum refund of the estimated amount if You were denied benefits and have completed all appeals (or reapplications) We have determined are necessary.

**Recurrent Disability:** If Your current Disability is:

1. due to the same causes(s) as Your prior Disability, for which We made a payment; and
2. is caused by a worsening of Your condition;

We will treat it as part of Your prior claim.

You will not have to complete another Elimination Period if You return to Active Work for Your Employer for 14 consecutive days or less. Your Disability will be subject to all of the Policy provisions as Your prior claim.

Any Disability which occurs after 14 consecutive days from the date Your prior claim ended will be treated as a new claim. Your new claim will be subject to all of the Policy provisions, including the Elimination Period.

If You become eligible for benefits under any other group short term disability policy, You will not be eligible for payments under the Policy.

**Multiple Causes:** If a period of Disability is extended by a new and unrelated cause while benefits are payable, benefits will continue while You remain Disabled, however:

## SHORT TERM DISABILITY BENEFIT

1. benefits will not continue beyond the end of the original Maximum Benefit Duration; and
2. any Exclusions and Short Term Disability Pre-Existing Conditions Exclusion will apply to the new cause of Disability.

**Concurrent Disabilities:** If You have one continuous period of Disability that is caused by more than one Sickness or Injury, Your Benefits will be paid as if the Disabilities were caused by one Sickness or one Injury. We will not pay benefits for more than one continuous period of Disability at the same time. If more than one benefit duration is applicable to Your period of Disability, We will pay the longest duration, subject to all other limitations and provisions of the Policy.

**Termination of Benefits:** We will stop making Your Weekly Payments and Your claim will end on the earliest of:

1. the date You are no longer Disabled according to the terms of the Policy;
2. the date You reach the end of the Maximum Benefit Duration;
3. the date You fail to provide proof of continuing Disability;
4. the date Your Disability Earnings exceed the amount allowable under the Policy;
5. the date You choose not to increase the number of hours You work or the number of duties You perform, which would have increased Your Disability Earnings;
6. the date You refuse to be examined by a Physician, if such an exam is requested by Us;
7. the date You refuse to be interviewed by one of Our representatives;
8. the date You cease to be under the Regular Care of a Physician; and
9. the date You die.

If You are a citizen of the United States and You are receiving Treatment outside of the United States, We may require that You return to the United States for Treatment. Failure to return, if required, may result in the termination of Your benefits.

## SHORT TERM DISABILITY REHABILITATION BENEFIT

**Rehabilitation Benefit:** During the course of Your Disability, Our Vocational Rehabilitation Consultant may review Your claim to determine if Our Rehabilitation Program would assist You in Your return to Active Work. If We determine that You are an eligible candidate for the Rehabilitation Benefit:

1. We will arrange for the services to be provided; and
2. We will pay for such program.

Your participation in Our Rehabilitation Program is voluntary.

Our Rehabilitation Program may include the following assistance:

1. coordination with Your Employer to assist in Your return to Active Work;
2. evaluation of adaptive equipment to allow You to work;
3. vocational evaluation to determine how Your Disability may impact Your employment options;
4. job placement services;
5. resume preparation;
6. job seeking skills training;
7. retraining for a new occupation; and
8. relocating that may be part of an approved return to work program.

We will work with Your Physician and other appropriate specialists to develop a plan that best suits Your needs.

## SHORT TERM DISABILITY LUMP SUM SURVIVOR BENEFIT

**Lump Sum Survivor Benefit:** We will pay a lump sum benefit, as shown in the Schedule of Benefits if:

1. You are receiving or are entitled to receive Weekly Payments at the time of Your death; and
2. Your Disability had continued for at least 15 consecutive days.

Upon receipt of proof of Your death, We will first apply any Lump Sum Survivor Benefit to any overpayment which may exist on Your claim. If there is no overpayment, the Lump Sum Survivor Benefit will be paid to:

1. Your spouse, if living, otherwise;
2. Your children.

If You have no living spouse or children, payment will be made to Your estate.



## EXCLUSIONS AND LIMITATIONS

**Exclusions:** We will not cover a Disability contributed to or caused by:

1. an act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;
2. intentionally self-inflicted Injuries;
3. active participation in a riot;
4. committing or attempting to commit a crime, or participating or attempting to participate in a crime;
5. an Occupational Sickness or Injury for Short Term Disability benefits if benefits are issued on a non-occupational basis. However, We will cover Disabilities due to an Occupational Sickness or Injury for partners or sole proprietors who cannot be covered by Workers' Compensation Law; or
6. elective cosmetic surgery.

For any period of time during which You are incarcerated or under House Arrest:

1. We will not make a benefit payment; and
2. after completion of the applicable Elimination Period, We will reduce the applicable Maximum Benefit Duration.

**Short Term Disability Pre-Existing Condition Exclusion:** We will not cover any Disability that begins during the first 12 months after Your Effective Date of insurance and which:

1. is caused by;
2. is contributed to; or
3. results from;

a Pre-Existing Condition or medical or surgical treatment for a Pre-Existing Condition.

**Short Term Disability Pre-Existing Condition** means any Sickness or Injury including Mental Illness, Substance Abuse or Subjective Symptoms for which You:

1. were diagnosed by; or
2. received Treatment from;

a Physician within 3 months prior to Your Effective Date of insurance.

## CLAIM INFORMATION

All benefits payable under the Policy will be paid according to the following provisions.

**Notice of Claim:** You, the person who has the right to claim benefits or Your authorized representative, must give Us, written notice of a claim, at Our Home Office, within 30 days after the date of loss. If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

The claim form is available from Your Employer, or can be requested from Us. If the form is not received from Us within 15 days of a request, written Proof of Claim should be sent to Us without waiting for the form. Written proof must fully describe the nature and extent of the claim.

**Proof of Claim:** Written Proof of Claim must be filed within 90 days of the loss. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of Claim may include the following:

1. a completed claim form;
2. a certified copy of the death certificate (if applicable);
3. Your enrollment form;
4. documentation of:
  - a. the date Your disability began;
  - b. the cause of Your disability; and
  - c. the prognosis of Your disability;
5. all medical information, including reports of diagnostic testing and photocopies of medical records, including histories;
6. physical, mental or diagnostic examinations and treatment notes;
7. the names and addresses of all:
  - a. Physicians or other qualified medical professionals You have consulted;
  - b. hospitals or other medical facilities in which You have been treated; and
  - c. pharmacies which have filled Your prescriptions within the past three years;
8. Your signed authorization for Us to obtain and release medical, employment, and financial information (if applicable);
9. documentation of Your hours worked, earnings and all other types of income;
10. proof of any Employer approved Leave of Absence; or
11. any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

You and Your Employer must fill out the applicable designated section of the claim form and then give it to Your attending Physician. The Physician should fill out their section of the form and send it directly to Us.

We may request that You provide proof of continuing disability, satisfactory to Us, indicating that You are under the regular care of a Physician. The proof, provided at Your expense, must be received within 30 days of a request by Us.

In some cases, You will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of Your Proof of Claim, or proof of continuing disability. We will deny Your claim or stop making Your payments if the appropriate information is not submitted.

## CLAIM INFORMATION

You must notify Us immediately when You return to work in any capacity.

**Payment of Claim:** Except as otherwise noted for specified additional benefits that may be included in the Policy, all Disability benefits are payable to You. If a benefit is payable to Your estate, to a minor or to someone who is not competent to give a valid release, We have the right to pay up to \$3,000 to any of Your relatives whom We consider entitled. Any amount We pay in good faith releases Us from further liability, but only for the amount paid.

**Receipt of Payments:** We will pay a claim for loss of life after We receive due Proof of Claim. However, if special circumstances require an extension, We will provide You or Your authorized representative with:

1. You are Disabled;
2. the applicable Elimination Period, if any, has been met; and
3. We approve Your claim.

If You are Disabled and working, proof of Disability Earnings will be required before benefits are paid.

At Our expense, We may require You to be examined:

1. by Physicians, or Vocational Rehabilitation Consultants of Our choice; and
2. as often as it is reasonable.

We may also require You to be interviewed by an authorized representative of Ours. Refusal to be examined or interviewed may result in denial or termination of Your claim.

**Time of Claim Payment:** We will pay a claim for loss after We receive due Proof of Claim. However, if special circumstances require an extension, We will provide You or Your authorized representative with:

1. a description of any further proof needed to complete the claim; and
2. an explanation of why such material is needed.

Benefits for a covered loss will then be paid upon receipt of all proper Proof of Claim. If We have not paid the claim when due, and We have not denied it for valid reasons, the benefit due will accrue interest at the rate of 1.5% per month until the claim is paid.

**Legal Action:** You may not bring suit to recover under this section until 60 days after You have given Us written Proof of Claim. No suit may be brought more than three years after the date of loss.

**Overpayment of Claim:** We have the right to recover any overpayments due to fraud, Your receipt of Other Income Benefits or any error We make in processing a claim. You must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from Your beneficiary or Your spouse if living, otherwise children under the age of 26 or estate.

**Reimbursement:** We have the right to request to be reimbursed for any benefit payments made or required to be made under the Policy for a Disability for which You recover payment from a third party. If You recover payment from a third party as:

1. a legal judgment;
2. an arbitration award; or
3. a settlement or otherwise;

You must reimburse Us for the lesser of:

1. the amount of payment made or required to be made by Us; or
2. the amount recovered from the third party less any reasonable legal fees associated with the recovery.

## CLAIM INFORMATION

**Conformity with State or Federal Statutes:** If any provision of Your Certificate conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

**Fraud:** We will use all means necessary to support fraud detection, investigation, and prosecution. Submission of false or misleading information may result in denial of Your claim, and may be subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

**Contestability:** We may not contest the validity of Your insurance, except for the non-payment of premiums, after it has been in force for two years from its date of issue. Statements made in any signed application relating to such insurability will not be used to contest the validity of the insurance after such insurance has been in force for two years from its date of issue. In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

**Misstatement of Age:** If Your age has been misstated, premiums will be adjusted. If the amount of the benefit is based on age, the benefit will be adjusted based upon Your correct age.

**Workers' Compensation:** The Policy does not provide benefits required by any Workers' Compensation laws.

**Employee Outreach Services:** We may provide Outreach Services for You, if You have a Disability that may interfere with Your recovery and return to work.

Employee Outreach Services will be provided at Our discretion and may include, but are not limited to:

1. service provider referrals; and
2. identifying available community and state resources that may be helpful in Your recovery and return to work.

**Social Security Assistance:** If You are receiving a payment from Us, We can provide advice regarding Your Social Security Disability benefits claim and assist You with Your application or appeal.

Receiving Social Security Disability benefits may enable:

1. You to receive Medicare after 24 months of Disability payments;
2. You to protect Your retirement benefits; and
3. Your family to be eligible for Social Security benefits.

We can assist You in obtaining Social Security disability benefits by:

1. helping You find appropriate legal representation or other assistance; and
2. obtaining medical and vocational evidence.

## CERTIFICATE MODIFICATIONS RIDER

### Modification(s) to the Certificate

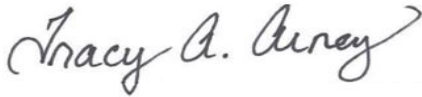
**Policyholder:** ENNOVA LLC

**Policy Number:** 1788761

It is agreed that the Certificate is amended as follows:

Effective June 1, 2026, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate, and all other conditions apply:

Signed for UnitedHealthcare Insurance Company by:



Tracey A. Arney, Secretary



Robert Hunter, President

**UnitedHealthcare Insurance Company**

**Hartford, Connecticut 06103-3408**

## CERTIFICATE MODIFICATIONS RIDER

### STATUTORY PROVISIONS

#### ALASKA

Residents of the state of Alaska, the following provisions are included to bring your Certificate into conformity with Alaska state law:

##### **Definitions**

If **Domestic Partner** coverage is included, it is amended so that any references to gender (i.e., “of the opposite or same sex” or “of the same sex”) are removed.

##### **Claim Information**

**Overpayment of Claim** is amended to advise that we have the right to recover any overpayments within 180 days of payment of a benefit.

#### ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

##### **Insurer Information Notice**

Any questions regarding the Policy may be directed to:

UnitedHealthcare Insurance Company

Administrative Offices

9900 Bren Road East

Minnetonka, MN 55343

1-866-615-8727

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department

1 Commerce Way, Suite 102

Little Rock, Arkansas 77202

#### MASSACHUSETTS

Residents of the state of Massachusetts, the following provision is included to bring your Certificate into conformity with Massachusetts state law:

##### **Continuation and Reinstatement Provisions**

The following section of the Continuation of Insurance is amended to add the exception of Cessation of Active Work and Plant Closing:

Continuation Provisions, with the exception of Cessation of Active Work and Plant Closing:

1. leaves of absence must be approved in writing by Your Employer; and
2. when combined, will not extend longer than 3 months from the date You were last Actively at Work.

## CERTIFICATE MODIFICATIONS RIDER

The following **Continuation Provisions** are added:

**Status Change:** If You are an Employee, but no longer in an Eligible Class due to a reduction in the number of scheduled hours You work, Your insurance may be continued for 90 consecutive days after the date Your scheduled hours were reduced.

**Cessation of Active Work:** Pursuant to Massachusetts state law, Your insurance may be continued for 31 days from the date You terminate Your employment with Your Employer, unless You become eligible for similar benefits under another group plan prior to the end of such 31 day period.

### MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota situated Employers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits

Contract Services

Administrative Offices

9900 Bren Road East

Minnetonka, MN 55343

#### Claim Information

**Time of Claim Payment** is amended be paid not more than 60 days after receipt of due Proof of Claim.

**Legal Actions** is amended to extend the timeframe in which no suit may be brought from three years after the date of loss to five years.

### MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

#### Claim Information

**Time of Claim Payment** is amended be paid not more than 30 days after receipt of due Proof of Claim, payment will include interest from the 30th day to the date the claim is paid at a rate less than required by Montana law.

**Overpayment of Claim** is amended to limit the time frame for Us to request reimbursement for overpayment to 30 days.

### NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

Cancellation notice disclosure:

**Important Cancellation Information. Please read the provision entitled Covered Person Termination of Insurance in the Eligibility, Effective Date and Terminations Provisions Section.**

### **This Policy is not a Medicare Supplement Contract**

#### Definitions

If Dependent coverage is included, the definition of **Hospital** is amended to include: "In North Carolina, Hospital also means a duly licensed State tax-supported institution which may be a specialty facility for one particular type of illness or one that may not have an operating room and related equipment for

## CERTIFICATE MODIFICATIONS RIDER

surgery. State tax-supported institutions includes community mental health centers and other health clinics which are certified as Medicaid providers.”

### **Exclusions and Limitations**

If the following exclusions are included, they are amended as follows:

- the Act of Accident of War exclusion is amended to include “The term “war” does not mean an act of terrorism. This exclusion does not apply if an insured is a known service member and such was known at the time of enrollment.”
- the exclusion for an Occupational Sickness or Injury, if Short Term Disability is included, it is replaced with: “an Occupational Sickness or Injury for Short Term Disability benefits which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the Employee, Employer or workers' compensation insurance carrier according a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act if benefits are issued on a non-occupational basis. However, We will cover Disabilities due to an Occupational Sickness or Injury for partners or sole proprietors who cannot be covered by Workers' Compensation Law”;

### **Claim Information**

**Proof of Claim** is amended to extend the timeframe in which written proof of claim must be filed, to 180 days. Also, for continued Disability, if under the Regular Care of a Physician, the proof will be provided at Our expense.

**Legal Actions** is amended to limit the timeframe in which no suit may be brought to 60 days after proof has been provided.

## **NORTH DAKOTA**

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

Right to return disclosure:

**You have 10 days to review this Certificate. If You are not satisfied for any reason, You may send the Certificate back to Us within 10 days of its delivery. In that event, We will consider it void and refund all premium paid by You.**

### **Definitions**

If the Subjective Symptoms definition is included in your Certificate, it is considered removed.

### **Exclusions and Limitations**

If Pre-Existing Condition language is included, it is amended, that any reference to Subjective Symptoms is removed.

If the Long Term Care Subjective Symptoms Limitation is included in your Certificate, it is considered removed.

### **Claim Information**

**Legal Actions** is amended to extend the timeframe in which no suit may be brought from three years after the date of loss to five years.

## **OKLAHOMA**

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

Disclosure notice:



**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

**Exclusions and Limitations**

If the Act of Accident of War exclusion is included, it is amended as follows: “an act or Accident of war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.”

**Claim Information**

**Overpayment of Claim** is amended to advise that we have the right to recover any overpayments within 24 months following the payment of a benefit.

**TEXAS**

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

**UnitedHealthcare Insurance Company**

To get information or file a complaint with your insurance company:

**Call:** UnitedHealthcare Insurance Company

**Toll-free:** 1-866-615-8727

**Mail:** United HealthCare Insurance Company Administrative Offices

9900 Bren Road East, Minnetonka, MN 55343

**The Texas Department of Insurance**

To get help with an insurance question or file a complaint with the state:

**Call with a question:** 1-800-252-3439

**File a complaint:** [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Email:** [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**Mail:** Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

**¿Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el

Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

**UnitedHealthcare Insurance Company**

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

**Llame a:** UnitedHealthcare Insurance Company

**Teléfono gratuito:** 1-800-405-9090

**Dirección postal:** United HealthCare Insurance Company Administrative Offices  
9900 Bren Road East, Minnetonka, MN 55343

**El Departamento de Seguros de Texas**

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

**Llame con sus preguntas al:** 1-800-252-3439

**Presente una queja en:** [www.tdi.texas.gov](http://www.tdi.texas.gov)

**Correo electrónico:** [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**Dirección postal:** Consumer Protection, MC: CO-CP, Texas Department of Insurance,  
P.O. Box 12030, Austin, TX 78711-2030

07/2023

**This provision applies only where the interpretation of the Policy is governed by the Employee Retirement Income Security Act (ERISA).**

### **STATEMENT OF EMPLOYEE ERISA RIGHTS**

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. Federal law and regulations require that a "Statement of ERISA Rights" be included in this description of the Plan.

You may examine, without charge, all Plan documents, including any insurance contracts, collective bargaining agreements, annual reports, summary plan descriptions and other documents filed with the Department of Labor. You can examine copies of these documents in the Plan Administrator's office or at other specified locations, or you can ask your supervisor where copies of the documents are available.

If you want a personal copy of Plan documents or related material, you should send a written request to the Plan Administrator. You will be charged only the actual cost of these copies.

You are entitled to 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.

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. These individuals, called "fiduciaries," have an obligation to administer the Plan prudently and to act in the interest of Plan participants and beneficiaries. The named fiduciary for this Plan is the Plan Sponsor. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 you the materials and pay you up to \$110 per day until you receive your materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or federal court provided you have exhausted the procedures and complied with the timeframes for review of the adverse claim decision provided below. 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 costs and legal fees. For example, if you are successful, the court may order the person you sued to pay those costs and fees. If you lose or if the court finds your suit to be frivolous, you may be ordered to pay these costs and fees.

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, contact the nearest Area Office of the Employee Benefits Security Administration, United States 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.

### **CLAIMS DENIAL FOR DISABILITY INSURANCE**

Notice of a decision to deny a claim (in whole or in part) shall be furnished to the claimant within 45 days following the receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the

claim for matters beyond the Plan's control or if additional information is needed from the claimant. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the expiration of the initial 45 day period.

The notice of extension shall indicate the special circumstances requiring the extension and the date by which the notice of decision with respect to the claim is expected to be furnished. If a claim is denied (in whole or in part) notice shall be provided to the claimant in writing and shall set forth: 1) the reason(s) for the denial which must contain a complete discussion of why the claim was denied, including the basis for disagreeing with the views of medical or vocational experts whose advice was obtained either by the claimant or by the plan in connection with the denial; 2) the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were relied on in denying a claim or a statement that none exists; 3) a statement that the claimant is entitled to receive, upon request, the entire claim file and other relevant documents; 4) reference to the provision(s) of the Plan on which the denial is based; 5) a description of any additional material or information necessary for the claimant to perfect the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; 6) an explanation of the claim review procedure. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations. If written notice of the denial is not furnished to the claimant within 45 days (or if an extension was required, 105 days) from the date the claim was received, the claim shall be deemed denied and the claimant shall then be permitted to proceed with the procedure set forth below.

## **REVIEW OF DENIED CLAIMS AND COMPLAINT PROCEDURE FOR DISABILITY INSURANCE**

If a covered person or any person claiming through a covered person wishes to have a denied claim reviewed, a written request must be sent to the address identified in the claim denial letter.

Any complaint or dispute related to review of denied claims shall be resolved in accordance with the procedure set forth by the Plan Sponsor and outlined below.

1. The complainant may contact the Insurance Carrier's service representative in an attempt to resolve the complaint in an informal manner.
2. If the complainant is not satisfied with any attempts at informal resolution, the complainant must submit a written request for review of a denied claim or a written notice of the complaint or dispute to the address identified on the claim denial letter within 180 days of receipt of the claim denial notice. The complainant may submit supporting documentation or information to be considered. The complainant must submit any requested additional information or documents.
3. A written notice of the final decision will usually be sent to the complainant within 45 days of receipt of the written request for review of a denied claim or notice of a complaint or dispute. However, if special circumstances require an extension of time to reach a final decision, written notice of the final decision will be sent as soon as possible following the expiration of the initial 45 day period, but no later than 90 days following receipt of the request for review of a denied claim or notice of a complaint or dispute. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the complainant prior to the expiration of the initial 45 day period. The written notice of the final decision must give specific reason(s) for the decision and include the above-referenced information set out above in the Claim Denial For Disability Insurance Section, items 1-4. A description of any applicable contractual limitations period and its expiration date must also be included. If the final written decision is not furnished to the complainant within 45 days (or if an extension was required, 90 days) from the date of receipt of the request for review of a denied claim or notice of a complaint or dispute, the request for review or the complaint or dispute shall be deemed to be rejected and denied on review. Notices must also be provided in a culturally and linguistically appropriate manner in certain situations.

4. Prior to the decision on appeal, the Plan must also provide any new or additional evidence or rationale that were not included at the denial stage and give the claimant notice and a fair opportunity to respond.