Certificate of Insurance

Securian Life Insurance Company • A Stock Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

POLICYHOLDER: Montefiore Medical Center

POLICY NUMBER: 70279

Effective: January 1, 2017

Read Your Certificate Carefully

You are insured under the group policy shown on the specifications page attached to this certificate. This certificate summarizes the principal provisions of the group policy that affect you. Every provision of the group policy which affects your insurance is summarized in this certificate. Nothing in the group policy will invalidate or impair the rights granted to you by this certificate or by law. You may also examine the group policy at the principal office of the policyholder during regular working hours.

Free Look

It is important to us that you are satisfied with this certificate after it is issued. If you are not satisfied with this certificate you may return it to us or our agent within 10 days after you receive it. You may also cancel this certificate by delivering or mailing a written notice to Securian Life Insurance Company (Securian Life), 400 Robert Street North, St. Paul, Minnesota 55101-2098 and returning the certificate before midnight of the 10th day after you receive this certificate. Notice given by mail and return of the certificate by mail are effective on being postmarked, properly addressed and postage prepaid. If you return the certificate, you will receive, within 7 days of the date we receive a notice of cancellation, a full refund of any premiums you have paid.

Secretary President

SECURIAN LIFE INSURANCE COMPANY REQUIRED DISCLOSURE STATEMENT

This certificate provides insurance only for ACCIDENTS. It does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

IMPORTANT NOTICE—THIS CERTIFICATE DOES NOT PROVIDE COVERAGE FOR SICKNESS

This certificate provides benefits for loss due to covered accidents. The conditions under which an accident is not covered are described in the Exclusions provision. This disclosure statement is a very brief summary of your certificate. The certificate itself sets for the rights and obligations of both you and us. It is therefore important that you READ YOUR CERTIFICATE CAREFULLY.

The expected benefit ratio for this insurance coverage is 78%. This ratio is the portion of future premiums which we expect to return as benefits, when averaged over all people covered under the group policy.

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ACCIDENTAL DEATH AND DISMEMBERMENT CERTIFICATE OF INSURANCE

AD&D INSURANCE CERTIFICATE SPECIFICATIONS PAGE

GENERAL INFORMATION

POLICYHOLDER: Montefiore Medical Center **POLICY NO.:** 70279

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Securian Life by the policyholder for Inclusion in the policy.

POLICY SITUS: The policy was issued and delivered in New York.

POLICY EFFECTIVE DATE: January 1, 2017. This specification page represents the plan in effect as of January 1, 2017.

This certificate and or certificate specifications page replaces any and all certificates and or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and or certificate specifications page previously issued to you with this new certificate and or specifications page.

GROUP: All new employees or members in the groups or classes eligible for such insurance will be added to such groups or classes for which they are respectively eligible.

The group is composed of all active employees of the policyholder and its associated companies working in the United States in the following class:

Class 1	All Registered Nurses part of the NYSNA, excluding North Central Bronx Hospital
Class 2	Physicians or all other active employees

WAITING PERIOD:

Classes: 1 and 2:	The period commencing with the employee's date of employment and ending with the first day of the month next following or coinciding with the date of employment.

MINIMUM HOURS PER WEEK REQUIREMENT: 17.5 hours per week or a 50% full-time equivlant.

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE:

Basic AD&D Insurance
An amount elected by the employee from the following options. AD&D can also be waived.

Eligible Class	Amount of Basic AD&D Insurance
Class 1:	$60,000
Class 2:	One times annual earnings, first rounded to the next higher $1,000 if not already a multiple thereof, then multiplied, subject to a maximum of $250,000.*

Voluntary AD&D Insurance

Eligible Class	Amount of Insurance
Class 1:	None
Class 2:	One, two, three, four, five, six, seven or eight times annual earnings, first rounded to the next higher $1,000 if not already a multiple thereof, then multiplied, subject to a maximum of $750,000.*

*The combined amount of basic and supplemental insurance for an employee shall not exceed the lesser of 9 times annual earnings or $1,000,000.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

AGE REDUCTIONS: The amount of insurance on an employee age 70 or older shall be a percentage of the amount otherwise provided by the plan of insurance applicable to such employee in accordance with the following table:

Basic AD&D:

Age of Employee	Amount of Insurance
70	90%
71	81%
72	73%
73	66%
74	60%
75	39%
80 and over	27%

Age reductions will apply the first of January following an insured employee's above stated birthdays. The newly reduced amount will be rounded to the next higher $1,000.

Voluntary AD&D: None.

CONTRIBUTORY/ NONCONTRIBUTORY: Basic insurance is contributory the first year and noncontributory insurance in following years.

Voluntary insurance is contributory insurance.

RETIREMENT REDUCTIONS: All AD&D insurance terminates upon retirement.

EFFECTIVE DATE OF INCREASES AND DECREASES DUE TO CHANGE IN ELIGIBLE CLASS OR EARNINGS: Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the first day of the month following the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement.

DEPENDENTS BENEFIT SCHEDULE

DEPENDENTS AD&D INSURANCE:

An employee must be insured for voluntary AD&D insurance to elect dependents AD&D insurance.

Spouse AD&D Insurance

Eligible Class	Amount of Insurance
Class 2 only:	An amount elected by the employee, in increments of $10,000, subject to a minimum of $10,000 and a maximum of the lesser of eight times the employee's annual earnings or $350,000.

Child AD&D Insurance

Eligible Class	Amount of Insurance
Class 2 only:	An amount elected by the employee, in increments of $10,000, subject to a minimum of $10,000 and a maximum of the lesser of one times the employee's annual earnings or $50,000.

GENERAL PROVISIONS FOR DEPENDENTS INSURANCE

AGE REDUCTIONS: None

CONTRIBUTORY/ NONCONTRIBUTORY: Dependent insurance is contributory insurance.

EFFECTIVE DATE OF INCREASES AND DECREASES DUE TO CHANGE IN ELIGIBLE CLASS OR EARNINGS: Requests for increases and decreases may be made only at annual enrollment or within 31 days of a qualified status change (as defined by the employer). Requests made due to a status change shall be effective on the first day of the month following the request. Requests made during an annual enrollment shall be effective on the general effective date of the annual enrollment. All increases are subject to the actively at work requirement for employees and the hospitalization/confinement clause for dependents.
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Definitions

age

Attained age as of policy anniversary date.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

certificate effective date

The date your coverage under this certificate becomes effective.

contributory insurance

Insurance for which the employee is required to make premium contributions.

earnings

An employee's basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees, seasonal employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated company.

insured

A person who is eligible for and becomes insured under the terms of this certificate.

licensed physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. The physician cannot be you or your spouse, children, parents, grandparents, grandchildren, brothers or sisters, or the spouse of any such individuals.

non-work day

A day on which the employee is not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long-term disability.

noncontributory insurance

Insurance for which the employee is not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page attached to this certificate.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer that the employee must satisfy prior to becoming eligible for coverage under this certificate. Any such waiting period is shown on the specifications page attached to this certificate.

we, our, us

Securian Life Insurance Company.

you, your, certificate holder

The individual who applies for and becomes insured under the group policy.

General Information

What is your agreement with us?

This certificate summarizes the principal provisions of your accidental death and dismemberment insurance provided by the group policy. The provisions summarized in this certificate are subject in every respect to the group policy. Your certificate, signed application and any subsequent signed application, contain the entire certificate.

Any statements made in your signed application will, in the absence of fraud, be considered representations and not warranties.

This certificate is issued in consideration of your application and the payment of the required premium.

No change or waiver of any provisions of the group policy, or any certificate issued under it, will be valid unless made in writing by us and signed by our president, a vice-president, our secretary, or an assistant secretary. No agent or other person has the authority to change or waive any provisions of the group policy, or of any certificate issued under it.

Can this certificate be amended?

Yes. Your consent is not required to amend this certificate. Any amendment will be without prejudice to

any claim for benefits incurred prior to the effective date of the amendment.

Who is eligible for insurance?

An employee is eligible if he or she:

(1) is a member of the eligible group and of an eligible class identified in the group policy; and
(2) works for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page attached to this certificate; and
(3) has satisfied the waiting period, if any; and
(4) meets the actively at work requirement described in the "What is the actively at work requirement?" provision of this section.

Unless otherwise specified in this certificate, you must continue to meet the actively at work requirement as specified in this certificate for your coverage to remain in force. Please refer to the provision entitled, "Can an insured employee's coverage be continued during sickness, injury, leave of absence or temporary layoff?

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as shown on the specifications page attached to the group policy, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor to have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase in the amount of insurance, an employee must be actively at work performing his or her customary duties at the employer's normal place of business, or at other places the employer's business requires him or her to travel.

Employees not working due to illness or injury do not meet the actively at work requirement nor do employees receiving sick pay, short-term disability benefits or long-term disability benefits.

If the employee is not actively at work on the date coverage would otherwise begin, or on the date an increase in his or her amount of insurance would otherwise be effective, he or she will not be eligible for the coverage or increase until he or she returns to active work. However, if the absence is on a non-work day, coverage will not be delayed provided the employee was actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, an employee is eligible to continue to be insured only while he or she remains actively at work.

When does your insurance become effective?

Your insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) if required, you apply for the insurance on forms which are approved by us; and
(3) we receive the required premium.

Can your coverage be continued during the employee's sickness, injury, leave of absence or temporary layoff?

Yes. Insurance may, according to uniform practices established by the employer under its plan of insurance, be continued on an insured employee, his or her insured spouse, if any, and/or his or her insured children, if any, if the employee is not actively at work due to sickness, injury, leave of absence or temporary layoff. Insurance will be deemed to continue until terminated by discontinuance of premium payments, written request or any other applicable termination provisions of this certificate.

Insurance continued for non-medical leave of absence or temporary layoff may not be continued beyond six months from the last day the employee was actively at work.

Insurance continued for sickness, injury or medical leave of absence may be continued as follows:

(1) if retirees are not an eligible class of insureds according to the policyholder's plan of insurance, continuation for medical leave of absence cannot be continued beyond the employee's retirement date.
(2) if retirees are an eligible class of insureds according to the policyholder's plan of insurance, continuation for medical leave of absence can be continued indefinitely. However, any reductions in the amount of insurance or any other change in policy provisions which apply at retirement will apply on the employee's retirement date.

For purposes of this provision, an employee's retirement date shall be the earlier of:

(1) the date he or she actually retires; or
(2) his or her presumed normal retirement date as established by the employer's applicable retirement plan. If no such date has been established, the employee's presumed retirement date shall be the date the employee attains age 65.

Coverage during a leave of absence and upon return from a leave of absence shall meet all state and federal requirements. If necessary, the above limits will be expanded in order to meet such requirements.

Practices established by the policyholder for determining eligibility for and continuance of insurance must be uniformly applied to all employees in a given class,

regardless of such employee's physical health or disability.

Premiums

When and how often are premiums due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a monthly basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

We may change the premium rate:

(1) on any premium due date following the expiration of any rate guarantee; or
(2) irrespective of any rate guarantee, anytime, if the policy terms are amended or the total amount of insurance in force changes by 25% or more.

We will notify the policyholder 120 days in advance of a change in premium rates.

Accidental Death and Dismemberment Benefit

What does accidental death or dismemberment by accidental injury mean?

Accidental death or dismemberment by accidental injury means that an insured's death or dismemberment results, directly and independently of all other causes, from an accidental injury which is unintended, unexpected, and unforeseen.

The injury must occur while the insured's coverage is in force. The insured's death or dismemberment must occur within 365 days after the date of the injury and while his or her coverage is in force.

If an insured lapses into a coma as a result of and within 365 days of a covered accidental injury, and such coma has lasted for a minimum of 31 days, we will pay a benefit equal to the lesser of:

(1) 1% of the insured's amount of insurance; or
(2) 1% of the difference between the insured's amount of insurance and the amount of any benefits paid under the loss schedule for the same accident.

This benefit will be paid monthly until the earliest of the following:

(1) the date the insured recovers such that he or she is no longer in a coma as defined herein; or
(2) the date of the insured's death. If an accidental death payment is due under this certificate, the amount of such payment will be reduced by the amount of insurance paid under this coma provision; or
(3) 100 months following the date monthly benefits commenced.

Coma means a state of profound unconsciousness with no evidence of appropriate responses to stimulation. The insured must be confined in a medical facility and diagnosed as comatose by a licensed physician.

What is the amount of the accidental death and dismemberment benefit?

The amount of the benefit shall be a percentage of the amount of insurance shown on the specifications page attached to this certificate. The percentage is determined by the type of loss as shown in the following table:

TYPE OF LOSS	PERCENT OF AMOUNT OF INSURANCE
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
Speech and Hearing	100%
One Hand and One Foot	100%
One Foot and Sight of One Eye	100%
One Hand and Sight of One Eye	100%
Quadriplegia	100%
Paraplegia	75%
Sight of One Eye	50%
Speech or Hearing	50%
One Hand or One Foot	50%
Hemiplegia	50%
Thumb and Index Finger of One Hand	25%
Uniplegia	25%

Loss of hands or feet means complete severance at or above the wrist or ankle joints. Loss of sight, speech, or hearing means the entire and irrecoverable loss of sight, speech, or hearing which cannot be corrected by medical or surgical treatment or by artificial means. Loss of thumb and index finger means complete severance of both the thumb and the index finger at or above the metacarpophalangeal joints. Quadriplegia means total paralysis of both upper and lower limbs. Paraplegia means total paralysis of both lower limbs. Hemiplegia means total paralysis of upper and lower limbs on one side of the body. Uniplegia means total paralysis of one limb.

A benefit is not payable for both loss of thumb and index finger of one hand and the loss of one hand for injury to the same hand as a result of any one accident.

Benefits may be paid for more than one accidental injury, but the total amount of insurance payable for all of an insured's losses due to any one accident, not including any amount paid according to the terms of the Additional

Benefits section of this policy, will never exceed such insured's full amount of insurance shown on the specifications page attached to this policy.

Can you request a change in the amount of your contributory insurance?

Yes. You can request an increase or a decrease in the amount of your contributory insurance as shown on the specifications page attached to this certificate. Requests may be made in writing, by telephone or any other method made available by us.

When will changes in coverage amounts be effective?

Increases and decreases in amounts of contributory insurance will be effective as shown on the specifications page attached to this certificate. All increases in the amount of insurance are subject to the actively at work requirement.

What are the notice of claim and proof of loss requirements?

Written notice of injury on which a claim may be based must be given to us within 20 days after the accident. Notice given by or on behalf of the insured or the beneficiary to Securian Life Insurance Company at 400 Robert Street North, Saint Paul, MN 55010, or to any authorized agent of Securian Life, with information sufficient to identify the insured, shall be deemed notice to us. Proof of loss must be furnished to us within 90 days after the date of loss. However, failure to give such notice and proof within the time provided will not invalidate the claim if it is shown that notice and proof were given as soon as reasonably possible.

When we receive written notice of claim, we will send the claimant our claim forms if he or she needs them. If the claimant does not receive the forms within 15 days, we will accept his or her written description as proof of loss.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit within 60 days of receipt at our home office of written proof satisfactory to us that you died or suffered a covered dismemberment as a result of a covered accidental injury. All payments by us are payable from our home office.

The benefit will be paid in a single sum. We will pay interest on the benefit from the date of your death or dismemberment until the date of payment. Interest will be at an annual rate determined by us, but never less than 0.1% per year or the minimum required by state law, whichever is greater.

To whom will we pay the accidental death or dismemberment benefit?

In the case of your accidental death, we will pay the accidental death benefit to the beneficiary or beneficiaries. All other benefits will be payable to you, if living, otherwise to your estate.

A beneficiary is named by you to receive the accidental death benefit to be paid at your accidental death. You may name one or more beneficiaries. You cannot name the policyholder or an associated company as a beneficiary.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in writing. To receive the accidental death benefit, a beneficiary must be living at the time of your accidental death. In the event a beneficiary is not living at the time of your accidental death, that beneficiary's portion of the accidental death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the accidental death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the accidental death benefit to:

(1) your lawful spouse, if living, otherwise;
(2) your natural or legally adopted child (children) in equal shares, if living, otherwise;
(3) your parents in equal shares, if living, otherwise;
(4) your brothers and sisters in equal shares, if living, otherwise;
(5) the personal representative of your estate.

Can you add or change beneficiaries?

Yes. You can add or change beneficiaries if all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A request to add or change a beneficiary must be made in writing or in any other method made available by the employer or us. All requests are subject to our approval. A change will take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving your request.

Exclusions

What are the exclusions under this certificate?

In no event will we pay the accidental death or dismemberment benefit where the insured's death or dismemberment results from or is caused directly or indirectly by any of the following:

(1) suicide or attempted suicide; or

(2) intentionally self-inflicted injury or any attempt at self-inflicted injury, whether sane or insane; or
(3) the insured's participation in or attempt to commit a felony; or
(4) bodily or mental infirmity, illness or disease, including bacterial infection, other than infection occurring simultaneously with, and as a result of, the accidental injury; or
(5) medical or surgical treatment including diagnostic procedures; or
(6) intoxication or influence of any narcotic unless administered on the advice of a physician; or
(7) travel or flight in or on any vehicle used for aerial navigation including getting in, out, on, or off such vehicle, if the insured is:
    (a) riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
    (b) acting as a pilot or a crew member of any aircraft, unless riding as a passenger; or
    (c) riding as a passenger in a non-chartered aircraft which is owned, leased, operated, or controlled by the insured employee's employer; or
    (d) a student taking a flying lesson, unless riding as a passenger; or
    (e) hang gliding; or
    (f) parachuting, except when the insured has to make a parachute jump for self-preservation; or
(8) war or any act of war, whether declared or undeclared; or
(9) riot or civil insurrection; or
(10) service in the armed forces or units auxiliary thereto.

Additional Benefits

Unless stated otherwise, additional benefits are payable to the same person or persons who receive the accidental death and dismemberment benefits. Additional benefits are paid in addition to any accidental death and dismemberment benefits described in the Accidental Death and Dismemberment section, unless otherwise stated. All provisions of the certificate, including but not limited to the Exclusions section, shall apply to these additional benefits.

Adaptive Home and Vehicle Benefit

What is the adaptive home and vehicle benefit?

If an insured suffers a loss other than loss of life and a benefit is payable under the AD&D benefit, we will pay for an insured's principal residence to be made accessible and/or an insured's private automobile to be made drivable or rideable. These one-time alteration expenses must be incurred within two years from the date of the accident. An insured's benefit will be the lesser of:

(1) 10% of his or her amount of AD&D insurance; or
(2) the actual alteration expense; or
(3) $10,000.

The Adaptive Home and Vehicle Benefit will be payable only if:

(1) a physician certifies the benefit is needed to accommodate a physical disability; and
(2) the alteration or modification is made by someone experienced in such adaptations; and
(3) the alteration or modification is in compliance with applicable laws or requirements for the approval by the appropriate government authorities; and
(4) the alteration or modification expenses do not exceed the usual level of charges for similar alterations or modifications in the locality where the expense is incurred.

Disappearance Benefit

What is the disappearance benefit?

If an insured's body has not been found after one year from the date the conveyance in which he or she was traveling disappeared, exploded, sank, became stranded, made a forced landing or was wrecked, it shall be presumed, subject to all other terms of the policy, that the insured has died as a result of an accidental injury which was unintended, unexpected and unforeseen. Such death shall be considered a covered loss under this certificate.

Exposure Benefit

What is the exposure benefit?

If an insured is unavoidably exposed to the elements by reason of a covered accident and suffers a loss that is included in the list of covered losses as a result of such exposure, such loss will be covered under the terms of this certificate.

Hospital Benefit

What is the hospital benefit?

If an insured requires hospitalization as a result of a covered accident, an additional benefit will be paid to you during such hospitalization. After a seven-day waiting period, a monthly benefit equal to 1% of the insured's amount of insurance will be paid, subject to a maximum of $1,000 per month for up to 12 months.

Payments for periods of less than a full month will be made on a pro-rata basis. If the period of hospitalization exceeds seven days, the benefit will be paid retroactively to the first day of hospitalization. No benefit is payable for hospitalizations of seven days or fewer.

Rehabilitative Physical Therapy Benefit

What is the rehabilitative physical therapy benefit?

If an insured suffers an injury which results in a covered dismemberment, we will pay an additional benefit for rehabilitative physical therapy which is prescribed by the attending physician or surgeon. The benefit will be equal to the lesser of:

(1) 10% of the insured's amount of insurance; or
(2) $10,000.

Seatbelt Benefit

What is the seatbelt benefit?

If an insured dies as a result of a covered accident which occurs while he or she is driving or riding in a private passenger car, we will pay an additional accidental death and dismemberment benefit equal to the lesser of 10% of the insured's amount of insurance or $10,000.
In order to be eligible for this benefit, the following must apply:

(1) the private passenger car was equipped with seatbelts; and
(2) a seatbelt was in proper use by the insured at the time of the accident as certified in the official accident report or by the investigating officer; and
(3) at the time of the accident, the driver of the private passenger car was not intoxicated, impaired, or under the influence of alcohol or drugs.

Seatbelt means a properly installed seatbelt (or child restraint if the insured is a child), lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration or any successor governmental agency. A private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

Termination

When does your insurance end?

Your insurance ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements, unless the insurance can be continued under the portability provisions, if any; or
(3) the date the group policy is amended so you are no longer eligible, unless the insurance can be continued under the portability provisions, if any; or
(4) 60 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

If your insurance under this certificate terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by us within 31 days of the date of termination and during your lifetime.

Unless otherwise specified in this certificate, you must continue to meet the actively at work requirement as specified in this certificate for your coverage to remain in force. Please refer to the provision entitled, "Can an insured employee's coverage be continued during sickness, injury, leave of absence or temporary layoff?

Can your coverage be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, and you become eligible again within three months after the date your coverage terminated, such coverage under this certificate, including all benefits previously terminated, may be reinstated.

Your coverage under this certificate shall be reinstated automatically, without satisfaction of any waiting period. The amount of insurance will be that which applies to the classification to which you then belong, on the date you again become eligible. If the policyholder's plan of insurance provides for contributory insurance under this certificate, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earliest of the following to occur:

(1) 60 days (the grace period) after the due date of any premiums which are not paid; or
(2) on any subsequent policy anniversary after the date the number of employees insured is less than any minimum established by us or as required by applicable state law; or
(3) 120 days after we provide the policyholder with notice of our intent to terminate the group policy.

Family Coverage

If you have dependents, you may elect accidental death and dismemberment coverage for your eligible dependents as described below. All provisions of the certificate applicable to an "insured," including but not limited to references in the Exclusions and Additional Benefits sections, shall apply to a dependent insured hereunder.

What members of your family are eligible for this benefit?

The following members of your family are eligible for this benefit:

(1) your lawful spouse and who is not legally separated from you and who is not eligible for insurance as an employee under this policy; and
(2) your children, stepchildren, and legally adopted children for whom eligibility begins at live birth (stillborn or unborn children are not eligible) and ends at the end of the calendar year in which the

child attains age 26. Children age 26 or older are also eligible if they are physically or mentally incapable of self-support, were incapable of self-support prior to age 26 and are financially dependent on the employee for more than one-half of their support and maintenance.

If both parents of a child qualify as insured employees under the group policy, the child shall be considered a dependent of only one parent for purposes of this benefit. If any child qualifies as an insured employee under the group policy, he or she is not eligible to be insured as a dependent child.

When does insurance on a dependent become effective?

Insurance on a dependent becomes effective on the date when all of the following conditions have been met:

(1) the dependent meets all eligibility requirements; and
(2) if required, you apply for dependents coverage on forms which are approved by us; and
(3) we receive the required premium.

Any dependent who, subsequent to the effective date of your certificate supplement for dependents accidental death and dismemberment insurance, meets the requirements of this provision will become insured on the date he or she so qualifies unless additional premium is required. If additional premium is required, the insurance of such later-acquired dependent shall be effective under the same conditions which apply if you were then first becoming eligible for dependents insurance under this certificate.

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. However, in no event will insurance on a dependent be effective before your insurance under this certificate is effective.

What is the amount of the accidental death and dismemberment benefit for each insured dependent?

The amount of insurance for a dependent is shown on the specifications page. The Accidental Death and Dismemberment section found earlier in this cerificate describes the amount of benefits, which are based on the insured's amount of insurance.

When will the accidental death or dismemberment benefit be payable?

We will pay the accidental death or dismemberment benefit upon receipt at our home office of written proof satisfactory to us that an insured dependent died or suffered dismemberment as a result of an accidental injury. All payments by us are payable from our home office.

The benefit will be paid in a single sum. We will pay interest on the benefit from the date of the insured dependent's death or dismemberment until the date of payment. Interest will be at an annual rate determined by us, but never less than 0.1% per year or the minimum required by state law, whichever is greater.

To whom will we pay a dependents accidental death or dismemberment benefit?

A dependents accidental death or dismemberment benefit will be paid to you, if living, otherwise to your estate.

Dependents Benefit Termination

When does an insured dependent's coverage terminate?

An insured dependent's coverage terminates on the earliest of the following:

(1) the date the dependent no longer meets the eligibility requirements; or
(2) 60 days (the grace period) after the due date of any unpaid premium if the premium remains unpaid at that time; or
(3) the last day for which premium contributions have been made following an insured employee's written request that insurance on his or her dependents be terminated; or
(4) the date the employee is no longer covered under the group policy.

The insured employee must notify us or the employer when a dependent is no longer eligible for coverage under this benefit so that premiums may be discontinued. All premiums paid for dependents who are no longer eligible for coverage under this benefit will be refunded without any payment of claim.

Additional Information

Do we have the right to obtain independent medical verification?

Yes. We retain the right to have an insured medically examined at our expense whenever a claim is pending and, where not forbidden by law, we reserve the right to have an autopsy performed in the case of death.

What if an insured's age has been misstated?

If an insured's age has been misstated, the accidental death or dismemberment benefit payable will be that amount to which the insured is entitled based on his or her correct age.

A premium adjustment will be made to the premium you pay for the insured's noncontributory insurance and to the premium an insured pays for contributory insurance, if any, so that the actual premium required at the insured's correct age is paid.

When does an insured's insurance become incontestable?

Except for fraud or the non-payment of premiums, after the insured's insurance has been in force during his or her lifetime for two years from the effective date of his or her coverage, we cannot contest the insured's coverage. However, if there has been an increase in the amount of insurance for which you voluntarily apply then, to the extent of the increase, any loss which occurs within two years of the effective date of the increase will be contestable.

Any statements the insured makes in his or her signed application will, in the absence of fraud, be considered representations and not warranties. Also, any statement an insured makes will not be used to void his or her insurance, or defend against a claim, unless the statement is contained in the signed application attached to the insured's certificate, which is signed by you and a copy has been furnished to your or your beneficiary.

Our liability with respect to any contested amount of insurance will be limited to the premiums paid and attributable to the contested amount.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument and you file the original instrument or a certified copy with us at our home office.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate or in the group policy is in conflict with the laws of the state governing the group policy or the certificates, the provision will be deemed to be amended to conform to such laws.

Legal Actions

No legal action may be brought to recover on this policy within the first sixty days after written proof of loss has been given as required by this policy. No such action may be brought after three years from the time written proof of loss is required to be given.

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	Montefiore Medical Center Insured Welfare Benefits Plan
Plan Sponsor (usually the employer)	Name: Montefiore Medical Center Address: 111 East 210th Street, Bronx, NY 10467
Employer ID	Employer Identification Number (EIN): 13-1740114
Plan Number	Plan Number: 508
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Securian Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator (usually the employer)	Name: Montefiore Medical Center Address: 111 East 210th Street, Bronx, NY 10467
Agent for Service of Legal Process	Name: Montefiore Medical Center Address: 111 East 210th Street, Bronx, NY 10467 Telephone Number: (914) 378-6550
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Securian Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Securian Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Securian Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Securian Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.

- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Securian Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Securian Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the 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:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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.

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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in 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 which 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 the cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA.

400 Robert Street North • St Paul, Minnesota 55101-2098

ACCIDENTAL DEATH AND DISMEMBERMENT CERTIFICATE OF INSURANCE