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**MONTEFIORE MEDICAL CENTER**
**ALL MEMBERS**

**Group Voluntary Term Life Insurance**
**Certificate**

# Underwritten by

# PRINCIPAL LIFE INSURANCE COMPANY

# Des Moines, IA 50392-0002

**Print Date: 12/17/2015**
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Summary Plan Description for Purposes of Employee Retirement Income Security Act (ERISA).

- This booklet-certificate (including any supplement) may be utilized in part in meeting the Summary Plan Description requirements under ERISA for insured employees (or those listed on the front cover) of the Policyholder who are eligible for Group Life insurance.

- A separate booklet-certificate will be issued if necessary to cover one or more separate classes of the Policyholder who are eligible for Group coverage. For further information, contact your plan administrator.

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Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

**THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED.** Please remove your enrollment material from your prior booklet, place it with this booklet, and destroy your prior booklet. If you have any questions about this new booklet, please contact your employer. In the event of future plan changes, you will be provided with a new Scheduled Benefits Summary, booklet-certificate or a booklet-certificate rider.

**PLEASE READ YOUR BOOKLET CAREFULLY.** We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

This booklet describes all the benefits available under the Group Policy underwritten by Us. However, if you have elected to not accept any available benefits, those benefits described in this booklet will not apply to you.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

**The Group Policy under which this booklet-certificate is issued is delivered in the State of New York and is subject to the laws of New York.**

**ACCELERATED BENEFITS** - Benefits paid as shown in this booklet - certificate for Accelerated Benefits are an advance of a portion of your Life Insurance benefit. This provision:

- accelerates and reduces your death benefit;

- is not intended to be used as long-term care insurance.

Effect on Government Benefits. If you receive payment of Accelerated Benefits, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others.

**Receipt of Accelerated Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Prior to applying for Accelerated Benefits, you should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or Dependents.**

**Tax Consequences. Receiving Accelerated Benefits from the Group Policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive Accelerated Benefits from the Group Policy.**

The insurance provided in this booklet is subject to the laws of the state of NEW YORK.

**PRINCIPAL LIFE INSURANCE COMPANY**
**Des Moines, IA 50392-0002**

**Principal Life Insurance Company**
**Des Moines, IA 50392-0002**

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**Principal Life Insurance Company**
**Des Moines, IA 50392-0002**

## SCHEDULED BENEFITS SUMMARY
## (revised effective December 10, 2015)

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

### MEMBER LIFE INSURANCE

If you die, your beneficiary will be paid the Scheduled Benefit then in force for you (however, see the exception noted below). Your specific Scheduled Benefit is shown on your Scheduled Benefits Summary and is based on your class:

| **Class 1** | ***Scheduled Benefit** |
|---|---|
| ALL REGISTERED NURSES PART OF THE NYSNA | The amount that is equal to 25%, 50%, 75% or 100% of your Basic Scheduled Benefit Amount as shown under the Policyholder's Group Term Life Insurance Policy. |

The Maximum Scheduled Benefit amount will be $60,000 and the Minimum Scheduled Benefit amount will be $2,500 subject to the reduction provision below.

| **Class 2** | ***Scheduled Benefit** |
|---|---|
| ALL OTHER ACTIVE MEMBERS | The amount that is equal to 1, 2, 3, 4, 5, 6 or 7 times your Basic Annual Compensation (this amount will be rounded to the next higher $1,000, if it is not already an exact multiple of $1,000).<br><br>Your Basic Life and Voluntary Term Life Scheduled Benefit amounts combined cannot exceed $1,000,000. |

Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions due to salary changes, age changes, and receipt of Accelerated Benefit payment plus any Accumulated Interest Charges.

* The Scheduled Benefit is subject to the Proof of Good Health requirements as described in the booklet on GH 115 A. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

For the age(s) shown below, your amount of insurance will be the percentage of the Scheduled Benefit (or approved amount, if applicable) as shown below:

| Age | % of Scheduled Benefit (or approved amount, whichever applies) |
|---|---|
| Age 70 | 90% |
| Age 71 | 81% |
| Age 72 | 73% |
| Age 73 | 66% |
| Age 74 | 60% |
| Age 75 | 39% |
| Age 80 | 27% |

**DEPENDENT LIFE INSURANCE**

If one of your Dependents dies, you will be paid the Scheduled Benefit then in force for that Dependent. The specific Scheduled Benefit is shown on your Scheduled Benefits Summary and based on the status of the Dependent:

**Class 2**

ALL OTHER ACTIVE MEMBERS

**Option 1**

| **Dependent** | ***Scheduled Benefit** |
|---|---|
| Spouse or Domestic Partner | $10,000 |
| Children (age at death) | |
| 0 days but less than 6 months old | $500 |
| 6 months and older | $5,000 |

**Option 2**

| **Dependent** | ***Scheduled Benefit** |
|---|---|
| Spouse or Domestic Partner | $20,000 |
| Children (age at death) | |
| 0 days but less than 6 months old | $1,000 |
| 6 months and older | $10,000 |

* The Scheduled Benefit for your spouse or Domestic Partner is subject to the Proof of Good Health requirements as described in the booklet on GH 125 C. If, because of these Proof of Good Health requirements, We approve an amount of insurance that is different than the Scheduled Benefit, your beneficiary will be paid the approved amount.

A Dependent's Scheduled Benefit will not exceed 100% of your Scheduled Benefit amount combined with any other Group Life Insurance Policy issued to the Policyholder by Us. A Dependent Spouse's or Domestic Partner's Scheduled Benefit will not exceed $20,000. A Dependent Child's Scheduled Benefit will not exceed $10,000.

## HOW TO BE INSURED - MEMBERS

## MEMBER LIFE INSURANCE

### Eligibility

To be eligible for insurance you must be a Member.

**Member** means any PERSON who is a Full-Time Employee of the Policyholder.

TEMPORARY MEMBERS

You will be eligible on the first of the insurance month coinciding with or next following the date you complete 3 months of continuous Active Work.

ALL OTHER MEMBERS

You will be eligible on the first of the insurance month coinciding with or next following the date you begin Active Work.

### Effective Dates - Actively at Work

If you are not Actively at Work on the date your insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

This Actively at Work requirement will be waived for Members who:

- are absent from Active Work because of a regularly scheduled day off, holiday, or vacation day; and
- were Actively at Work on their last scheduled work day before the date of their absence; and
- were capable of Active Work on the day before the scheduled effective date of their insurance or change in their insurance, whichever is applicable.

### Individual Incontestability

All statements made by any insured person (you or one of your Dependents) will be representations and not warranties. These statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and

- the statement is in written form signed by the insured person; and

- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary.

**Misstatements**

If a person's age is misstated, We may, at any time, equitably adjust premiums and benefits to reflect the correct age.

**Assignments**

Only assignments of Member Life Insurance will be allowed under the Group Policy and only if:

- they are not collateral assignments or assignments for consideration; and

- they are in Written form and recorded at Our home office in Des Moines, Iowa.

We will assume no responsibility for the validity of effect of any assignment

**Proof of Good Health**

In some instances, Proof of Good Health will be required to place your insurance in force. The type and form of required proof will be determined by Us. You will need to file Proof of Good Health:

- For requests other than a qualifying event or change in class, if you request insurance more than 31 days after the date you are eligible including any insurance you refuse and later request. You must pay the cost of obtaining proof in this instance.

- If you have failed to provide required Proof of Good Health or you have been refused insurance under the Group Policy at any prior time. You must pay the cost of obtaining proof in this instance.

- For requests other than a qualifying event or change in class, if you elect to terminate insurance and, more than 31 days later, you request to be insured again. You must pay the cost of obtaining proof in this instance.

- If you elect to terminate insurance due to either a qualifying event or change in class, no Proof of Good Health is required if you request to be insured again during an annual enrollment period.

- To become insured, initially and for later increases, for any Member Life Insurance Scheduled Benefit amount in excess of:

**For All Registered Nurses Part of the NYSNA:**

- $60,000

**For All Other Active Members:**

- 3 times Basic Annual Compensation not to exceed $750,000

We will pay the reasonable cost of proof required in this instance.

Exception: No Proof of Good Health is required for the initial excess insurance for Members insured on January 1, 2011.

- To become insured for any request for a Scheduled Benefit amount increase. We will pay the reasonable cost of proof required in this instance.

- To become insured for any Member Life Insurance Scheduled Benefit amount increase in excess of 10% due to change in your compensation. We will pay the reasonable cost of proof required in this instance.

- To become insured for any Member Life Insurance Scheduled Benefit amount increase if any previous Scheduled Benefit increase has been declined. You must pay the cost of obtaining proof in this instance.

- During an annual enrollment period, to make effective any Scheduled Benefit increase above one benefit increment.

**Effective Date for Initial Insurance**
**(Proof of Good Health Not Required)**

You must request initial insurance in a form provided by Us.

Your insurance will normally be in force on:

- the date you are eligible, if you make your request on or before that date; or

- the first of the insurance month coinciding with or next following the date of your request, if you make your request within 31 days after the date you are eligible.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

**Effective Date for Initial Insurance**
**(Proof of Good Health Required)**

If Proof of Good Health is required, your insurance will normally be in force on the later of:

- the date insurance would have been effective had Proof of Good Health not been required; or

- the first of the insurance month coinciding with or next following the date Proof of Good Health is approved by Us.

However, if you are not Actively at Work on the date insurance would otherwise be effective, your insurance will not be in force until the day you return to Active Work.

**Effective Date for Benefit Changes**
**(Proof of Good Health Not Required)**

If Proof of Good Health is not required, a change in your Scheduled Benefit amount because of a change in your status (compensation) will normally be effective on the date of the change in status. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

If Proof of Good Health is not required, a change in the Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will normally be effective on the date of change. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

If Proof of Good Health is not required, a change in your Scheduled Benefit amount because of a request by you will normally be effective the January 1 that next follows the date of the request. However, if you are not Actively at Work on the date the change would otherwise be effective, the change will not be in force until the day you return to Active Work.

Exception: decreases in Member Life Insurance Scheduled Benefit amounts are effective on the date noted above whether or not you are Actively at Work.

**Effective Date for Benefit Changes**
**(Proof of Good Health Required)**

If Proof of Good Health is required, a change in your Scheduled Benefit amount will normally be effective on the later of:

- the date the change would have been effective had Proof of Good Health not been required; or

- the date Proof of Good Health is approved by Us.

However, the exception noted above when Proof of Good Health is not required will also apply when Proof of Good Health is required.

**Termination**

Your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the date you cease to belong to a class for which insurance is provided; or
- the date the last premium is paid for your insurance; or
- any date desired, if requested by you before that date; or
- the date you cease to be a Member; or
- the date you cease Active Work; or
- the date you retire, if you are not eligible for Coverage During Disability.

If the Group Policy terminates, the Policyholder must advise you of the date of termination and refund or otherwise account for all contributions not used to pay premium. If the Group Policy terminates, you will have the right to convert to an individual life insurance policy as shown under Individual Purchase Rights - Conversion Privilege in GH 202.

**Continuation**

If you cease Active Work because of sickness or injury, you may be eligible for limited continuation of insurance. See the continuation provisions described on GH 117 A.

If you cease Active Work because of layoff, approved leave of absence, military leave of absence or sabbatical, insurance may be continued on a limited basis. See the continuation provisions described on GH 117 A.

Your insurance may also be continued under the continuation provisions described on GH 117 C and subject to the provisions of the Group Policy.

Your insurance may also be continued under the Portability provisions described on GH 304 and subject to the provisions of the Group Policy.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

If you have continued your insurance, you will have the right to convert to an individual life insurance policy as shown under Individual Purchase Rights - Conversion Privilege in GH 202 at any time during the continuation period.

## HOW TO BE INSURED - DEPENDENTS

## DEPENDENT LIFE INSURANCE

### Eligibility

You will be eligible for insurance for your Dependents on the later of:

- the date you are eligible for Member insurance; or
- the date you first acquire a Dependent.

### Effective Date

Dependent Insurance is available only with respect to Dependents of Members currently insured for Member Life Insurance. If a Member is eligible for Dependent insurance, such insurance will be in force under the same terms as described earlier for Member insurance, except:

- Insurance will not be effective unless you are insured for Member Insurance.
- If a Dependent spouse or Domestic Partner is in a Period of Limited Activity on the date initial Dependent Insurance would otherwise be effective, the Dependent will not insured until the Period of Limited Activity ends.

  However, this Period of Limited Activity requirement may be waived as described below.

  When insurance under the Group Policy replaces coverage under a Prior Plan, the Period of Limited Activity requirement may be waived for those Dependent spouses or Domestic Partners who:

  - are eligible and enrolled under the Group Policy on the date insurance would otherwise be effective; and
  - were covered under the Prior Plan on the date of its termination.

  In no event will the Period of Limited Activity requirement be waived for those Dependent spouses or Domestic Partners who, on the date of termination of the Prior Plan had the option, under the terms of the Prior Plan, to convert their coverage, under the Prior Plan, to an individual policy.

  NOTE: When insurance under the Group Policy replaces coverage under a Prior Plan and the Period of Limited Activity requirement is waived any Benefits Payable will be the lesser of the Scheduled Benefit of the Group Policy or the amount that would have been paid by the Prior Plan had it remained in force.

- If a Dependent is confined in a Hospital or Skilled Nursing Facility on the date an increase in Dependent Life Insurance Scheduled Benefits would otherwise be effective, the increase will not be in force until the confinement ends.

- Proof of Good Health will be required if insurance is requested under the Group Policy for a Dependent who was previously eligible to enroll under the Group Policy, but elected to waive coverage and later requests to be insured under the Group Policy.

- Any required Proof of Good Health will be with respect to the health of your Dependents.

- If Dependent insurance is then in force for any other Dependent, a new Dependent (other than a newborn child) will be insured on the date acquired, provided the new Dependent is not then confined in a Hospital or Skilled Nursing Facility.

- If Dependent insurance is then in force for any other Dependent, a newly born child will be insured on the date of birth, provided the child meets the definition of a Dependent Child.

**Individual Incontestability**

Your Dependents will be subject to the Individual Incontestability as described earlier for Member insurance.

**Misstatements**

Your Dependents will be subject to the Misstatements as described earlier for Member insurance.

**Termination**

Insurance for all of your Dependents will terminate on the earliest of:

- the date you cease to belong to a class for which Dependent insurance is provided; or

- the date Dependent Life Insurance is removed from the Group Policy; or

- the date the last premium is paid for your Dependent's insurance; or

- any date desired, if requested by you before that date; or

- the date your Member insurance ceases; or

- the date you retire, if you are not eligible for Coverage During Disability.

If the Group Policy terminates, the Policyholder must advise you of the date of termination and refund or otherwise account for all contributions not used to pay premium. If the Group Policy terminates, your Dependents will have the right to buy an individual life insurance policy as shown under Individual Purchase Rights - Conversion Privilege on GH 302.

Insurance for any one Dependent will terminate on the date he or she ceases to be your Dependent.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

**Continuation**

Your Dependent's insurance may also be continued as described under the continuation provisions described on GH 117 C and subject to the provisions of the Group Policy.

Your Dependent's insurance may also be continued under the portability provisions described on GH 304 and subject to the provisions of the Group Policy.

If you have continued your Dependent's insurance, you will have the right to convert to an individual life insurance policy for your Dependents as shown under Individual Purchase Rights - Conversion Privilege in GH 302 at any time during the continuation period.

## CONTINUATION OF INSURANCE AND REINSTATEMENT

### Sickness or Injury

If Active Work ends because of your sickness or injury, your insurance may be continued. The continued insurance will end for you on the earlier of:

- the date insurance would otherwise cease; or
- the date you recover.

If sickness or injury results in Total Disability, insurance may be continued as provided in GH 202.

### Layoff, Approved Leave of Absence, Military Leave of Absence, or Sabbatical

If Active Work ends because you are on layoff, approved leave of absence, military leave of absence or sabbatical, your insurance may be continued. The continued insurance will end for you on the earliest of:

- the date insurance would otherwise cease; or
- **For a layoff:** the date Active Work ends.
- **For an approved leave of absence:** the date six months after the end of the insurance month in which date Active Work ends.
- **For a military leave of absence:** the date six months after the end of the insurance month in which date Active Work ends.
- **For a sabbatical:** the end of the insurance month in which Active Work ends.
- the date you become covered under any other group policy; or
- the date one month after the date Active Work ends.

### Automatic Reinstatement

Your terminated insurance will be reinstated if:

- insurance ceases because of layoff or approved leave of absence; and
- you return to Active Work for the Policyholder within six months of the date insurance ceased.

Your reinstated insurance will be in force on the date of return to Active Work. However, the Actively at Work and Period of Limited Activity provision will apply. Also, Proof of Good Health will be required to place in force any Scheduled Benefit that would have been subject to Proof of Good Health had you remained continuously insured.

Only the period of time during which you are actually insured will be included in determining the length of your continuous coverage under the Group Policy. For this purpose the period of time during which your reinstated coverage was not in force:

- will not be considered an interruption of continuous coverage; and

- will not be used to satisfy any provision of the Group Policy which pertains to a period of continuous coverage.

# FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

## FMLA and Other Continuation Provisions

If you cease Active Work due to an approved leave of absence under the Federal Family and Medical Leave Act (FMLA), the Policyholder may choose to continue your insurance, subject to premium payment.

If the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

## Reinstatement

An Eligible Employee's terminated coverage may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA), subject to the Actively at Work and Period of Limited Activity requirements of the Group Policy.

# DESCRIPTION OF BENEFITS

## MEMBER LIFE INSURANCE

### Death Benefit

If you die while insured for Member Life Insurance, We will pay your beneficiary the Scheduled Benefit in force on the date of your death, less any unpaid premium and less any Accelerated Benefit payment and Accumulated Interest Charges as discussed later in this Section. If your beneficiary does not survive you, We will make payment in the following order of precedence:

- to your spouse or Domestic Partner
- to your children born to or legally adopted by you
- to your parents
- to your brothers and sisters
- if none of the above, to the executor or administrator of your estate or other persons as provided in the Group Policy.

However, if a beneficiary is suspected or charged with your death, the Death Benefit may be withheld until additional information has been received or the trial has been held. If a beneficiary is found guilty of your death, such beneficiary may be disqualified from receiving any benefit due. Payment may then be made to any contingent beneficiary or to the executor or administrator of your estate.

If you die by suicide within 24 months after the effective date of your Life Insurance, We will pay your beneficiary the amount of any premium paid by you to Us during the period of time your insurance was in force in lieu of the Scheduled Benefit (or approved amount, if applicable) in force on the date of your death. Any such payment will discharge Us to the full extent of such payment.

### Settlement of Proceeds

Unless otherwise elected by you or your beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

### Beneficiary

You should name a beneficiary at the time you enroll for insurance. You may later change your beneficiary by filing a written request with the Policyholder. See the Policyholder for change request forms. A change in your beneficiary will not be in force until the Policyholder receive(s) the change.

### Continuation (Member Life Insurance - Coverage During Disability)

If you cease Active Work for any reason, your insurance will normally terminate. However, if you cease Active Work because you are Totally Disabled, you might qualify to continue your Member Life Insurance and Dependent Life Insurance. This continuation is called Coverage During Disability. This Coverage During Disability provision does not apply to you if you have continued coverage under the Portability provision, as described on GH 304.

To be qualified for Coverage During Disability, you must:

- become Totally Disabled while insured for Member Life Insurance; and
- become Totally Disabled before age 70; and
- remain Totally Disabled continuously; and
- be under the regular care and attendance of a Physician; and
- send proof of Total Disability to Us within one year of the date Total Disability starts and as often thereafter as We may require; and
- return, without claim, any individual policy issued under your purchase rights as described below. Upon return of such policy, We will refund premiums paid, less dividends and less any outstanding policy loan balance; and
- submit to examinations by a Physician when We require (We will pay for these examinations and will choose the Physician).

If you qualify, Coverage During Disability will be in force on the earlier of:

- the day six months after the date your Total Disability began; or
- the date of your death.

Premium will not be charged for Member Life Insurance and Dependent Life Insurance while your Coverage During Disability is in force.

Coverage During Disability will cease on the earliest of:

- the date you are age 70; or
- the date you no longer qualify.

If you die while Coverage During Disability is in force, We will pay your beneficiary the Member Life Insurance benefit, if any, that would have been paid had you remained insured under the benefit schedule in force on the date your Total Disability began. Member Life Insurance benefits are subject to all reductions provided in the Group Policy including reductions

due to age changes, and receipt of an Accelerated Benefit payment plus any Accumulated Interest Charges.

Note that Coverage During Disability will not be in force and NO BENEFIT WILL BE PAID if written proof of Total Disability is not sent to Us within ONE YEAR of the date Total Disability starts. Failure to furnish such proof within the specified time will not invalidate or reduce any claim if it is shown that it was not possible to furnish proof within the specified time and that proof was furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**Accelerated Benefit**

An Accelerated Benefit is an advance (before death) payment of a part of your Member Life Insurance benefit. To qualify for an Accelerated Benefit, you must:

- be insured for a Member Life Insurance benefit of at least $10,000; and
- be Terminally Ill (expected to die within 12 months); and
- send a request for Accelerated Benefit payment to Us; and
- send proof, satisfactory to Us, of your Terminal Illness; and
- provide a release from the assignee, if your Member Life Insurance benefit has been assigned.

Proof of Terminal Illness will consist of a statement from your Physician, and any other medical information that We believe is needed to confirm your status.

You will be considered Terminally Ill if you have experienced a Qualifying Event and you are expected to die within twelve months of the date you request payment of Accelerated Benefits.

A Qualifying Event is a medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span.

If you qualify, We will pay you any amount you request; except that:

- only one Accelerated Benefit payment will be made during your lifetime; and
- you must request a minimum payment of the lesser of (1) 25% of your Member Life Insurance benefit; or (2) $50,000; and
- We will not pay you more than the lesser of (1) 75% of your Member Life Insurance benefit; or (2) $250,000.

We will pay you the Accelerated Benefit payment in a lump sum.

If an Accelerated Benefit is paid, the Member Life Insurance benefit otherwise payable to your beneficiary upon your death will be reduced by the sum of:

- Accelerated Benefit payment; plus

- Accumulated Interest Charges.

Accumulated Interest Charges will be the sum of interest charged for each day of the period from the date of your Accelerated Benefit payment to the date of your death, but not more than two years. The interest rate will be the greater of:

- the then current yield on the 90-day Treasury Bills available on the date of application for an Accelerated Benefit; or

- the then current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages - Monthly Average Corporates - published by Moody's Investor Services, Inc. or any successor thereto, for the calendar month ending two months before the date of application of an Accelerated Benefit payment;

but in no event will the interest rate exceed 8% per annum.

Following is an EXAMPLE of how this benefit affects the final death benefit.

BENEFIT EXAMPLE

| | |
|---|---|
| Member Life Insurance Benefit Amount | $ 100,000 |
| Accelerated Benefit Amount Requested<br>(Member would receive $75,000) | $ 75,000 |
| Accelerated Benefit paid on August 15<br>Member death occurs on November 15 | (92 days after payment) |
| Accumulated Interest Charges<br>($75,000 x .08) x (92 days/365 days) | $ 1,512 |
| Payment to Member's Beneficiary<br>($100,000 - $75,000 - $1,512) | $ 23,488<br>(less any unpaid premium) |

During the two-year period following payment of an Accelerated Benefit:

- termination of Active Work because of your Terminal Illness will not result in termination of your Member Life Insurance; and

- your Member Life Insurance and Dependent Life Insurance will be provided without premium charge.

Premium payment for your Member Life Insurance must be resumed if you are still living at the end of this two year period. At the end of the Premium Waiver Period, if contributions are required, the amount of premium charged to you will be the premium payment in effect prior to payment of the Accelerated Benefit. If the Group Policy has been terminated, you will qualify for Individual Purchase as described below.

**Individual Purchase Rights - Conversion Privilege**

You will have the right to convert to an individual life insurance policy without submitting Proof of Good Health:

- If your total Member Life Insurance terminates because you end Active Work or cease to be in a class eligible for insurance. In these instances, the maximum amount you may convert will be your Member Life Insurance amount in force before the termination, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

- If your total Member Life Insurance ceases because the group Policy terminates or is amended to exclude your insurance class or due to Total and Permanent Disability. In these instances, the maximum amount you may convert will be your Member Life Insurance amount in force before termination, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit payment and Accumulated Interest Charges as discussed earlier in this Section and less any amount for which you become eligible under any group policy within 45 days.

- If the Group Policy is amended to reduce your Scheduled Benefit or you transfer to a class that provides a lesser Scheduled Benefit. In these instances, the maximum amount you may convert will be your Member Life Insurance amount in force before the reduction, less the amount of Member Life Insurance benefit (if any) remaining in force and less any Accelerated Benefit payment and Accumulated Interest Charges as discussed earlier in this Section.

- If your Scheduled Benefit is reduced due to age; and

    - the reduction occurs on or after the date you attain age 60; and
    - the amount of the reduction is in an increment (or series of increments) equal to 20% or more of your Scheduled Benefit before the first reduction due to age.

    In this instance, the maximum amount you may convert will be the Scheduled Benefit amount in force the day before the reduction less the Scheduled Benefit amount in

force after the reduction less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

- If your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount you may convert will be the benefit amount in force on the date Total Disability ends, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

- If your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount you may convert will be the benefit amount in force on the date you cease Active Work, less any individual amount purchased earlier under these rights, and less any Accelerated Benefit and Accumulated Interest Charges as discussed earlier in this Section.

You must apply for individual purchase and pay the first premium to Us within 31 days after your coverage under the Group Policy ceases.

See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

**Notice of Conversion**

The Policyholder must give you written notice of the individual purchase right before or within 15 days after you qualify for individual purchase as shown above. Written notice will also be given by Us and mailed to the last known address that was furnished to Us by the Policyholder. If notice is not given within the 15-day period, you will be given 45 days after the date of such notice to apply individual purchase. However, if notice is not given within 90 days after qualification for individual purchase as shown above, the time allowed to exercise the individual purchase right will expire at the end of that 90-day period.

The individual policy will be for life insurance only in any one of the forms customarily issued by Us except term insurance (term insurance is available if your Life Insurance ceases due to Total and Permanent Disability). The individual policy may include preliminary term insurance for not more than one year following the effective date of the individual policy. No disability or other benefits will be included. The premium you pay will be at Our normal rate for your age on the individual policy's date of issue (except that, if the policy includes preliminary term insurance, your age at the end of the preliminary term period will be used for the remaining period covered by the individual policy).

If you die within the 31-day purchase period or within the period of time allowed for notice of individual purchase rights, your beneficiary will be paid the life insurance amount, if any, you had the right to convert. This payment will be made whether or not you have applied for an individual policy. We may deduct any premium that would have been payable during such time period from any benefits that may become payable.

## DESCRIPTION OF BENEFITS

## DEPENDENT LIFE INSURANCE

### Death Benefit

If one of your Dependents dies while insured for Dependent Life Insurance, We will pay the Scheduled Benefit in force for that Dependent, less any unpaid premium.

Payment will be to you if you survive the Dependent. If not, We will pay the beneficiary you named for Member Life Insurance. However, if you are suspected or charged with your Dependent's death, the Death Benefits may be withheld until additional information has been received or the trial has been held. If you are found guilty of the Dependent's death, you may be disqualified from receiving any benefit due. Payment may then be made to the executor or administrator of the Dependent's estate.

No payment will be made before We receive written proof of the Dependent's death.

If your Dependent dies by suicide within 24 months after the effective date of his or her Dependent Life Insurance, We will pay the amount of any premium, attributable to that Dependent, paid by you to Us during the period of time the Dependent Life Insurance for your Dependent was in force in lieu of the Scheduled Benefit in force on the date of your Dependent's death. Any such payment will discharge Us to the full extent of such payment.

### Individual Purchase Rights - Conversion Privilege

Your Dependent will have the right to convert to an individual life insurance policy without submitting Proof of Good Health:

- If Dependent Life Insurance for your Dependent ceases because your Dependent ceases to qualify as a Dependent; or because you die, terminate employment, or cease to be in a class eligible for insurance. In these instances, the maximum amount your Dependent may convert will be the amount of Dependent Life Insurance in force for the Dependent before termination, less any individual amount purchased earlier under these rights.

- If Dependent Life Insurance for your Dependent ceases because the Group Policy terminates or is amended to eliminate your Dependent Life Insurance. In these instances, the maximum amount your Dependent may convert will be the amount of Dependent Life Insurance in force for the Dependent before termination, less any individual amount purchased earlier under these rights, and less any amount for which the Dependent becomes eligible under any group policy within 45 days.

- If the Group Policy is amended to reduce the Dependent Life Insurance benefit or you transfer to a class that provides a lesser Dependent Life Insurance benefit. In these instances, the maximum amount your Dependent may convert will be the amount of Dependent Life Insurance in force for the Dependent before the reduction.

- If Dependent Life Insurance for your Dependent ceases because your Coverage During Disability ceases because Total Disability ends and you do not then become insured under the Group Policy within 31 days. In this instance, the maximum amount your Dependent may convert will be the amount of Dependent Life Insurance in force for the Dependent on the date of termination, less any individual amount purchased earlier under these rights.

- If Dependent Life Insurance for your Dependent ceases because your Accelerated Benefit Premium Waiver Period ceases and you do not qualify for Coverage During Disability. In this instance, the maximum amount your Dependent may convert will be the amount of Dependent Life Insurance in force for the Dependent on the date of termination, less any individual amount purchased earlier under these rights.

Your Dependent must apply for individual purchase and pay the first premium to Us within 31 days after the date his or her coverage under the Group Policy ceases. See the Policyholder for the proper forms. Any individual policy issued will be effective on the 32nd day.

The individual policy will be for life insurance only in any one of the forms customarily issued by Us except term insurance. The individual policy may include preliminary term insurance for not more than one year following the date of termination of the Dependent Life Insurance. No disability or other benefits will be included. The premium to be paid will be at Our normal rate for your Dependent's age on the individual policy's date of issue (except that, if the policy includes preliminary term insurance, your Dependent's age at the end of the preliminary term period will be used for the remaining period covered by the individual policy).

**Notice of Conversion**

The Policyholder must give written notice of the individual purchase right before or within 15 days after qualification for individual purchase as shown above. Written notice will also be given by Us and mailed to the last known address that was furnished to Us by the Policyholder. If notice is not given within the 15-day period, your Dependent will be given 45 days after the date of such notice to apply individual purchase. However, if notice is not given within 90 days after qualification for individual purchase as shown above, the time allowed to exercise the individual purchase right will expire at the end of the 90-day period.

If your Dependent dies within the 31-day purchase period or within the period of time allowed for notice of individual purchase rights, We will pay the life insurance amount, if any, the Dependent had the right to convert. This payment will be made whether or not your Dependent has applied for an individual policy. We may deduct any premium that would have been payable during such time period from any benefits that may become payable.

# DESCRIPTION OF BENEFITS

# PORTABILITY

## Group Policy Provisions

Except as provided below, coverage continued under this provision is subject to all other terms of the Group Policy. With respect to any notice you are required to provide to the Policyholder under other provisions of the Group Policy, such notice must be provided to Us by you while your coverage is continued.

## Member Life Insurance

### Eligibility

You will be eligible to continue your Member Life Insurance under this Portability feature on the date your employment ends for any reason, other than the termination of the Group Policy. Insurance may be continued under this section if:

- your coverage is not continued under Coverage During Disability provisions described in the booklet on GH 202; or

- you have not received a benefit under Accelerated Benefits provisions described in the booklet on GH 202.

### Amount of Continued Member's Coverage

The maximum amount of Member Life Insurance that may be continued is: An amount equal to the Scheduled Benefit in force on the date your employment ends. You may continue any lesser amount equal to a multiple of your Basic Annual Compensation in force on the date employment ends. You may not at any time increase the amount of coverage continued under this section.

Coverage During Disability as described in this booklet on GH 202-1 will not be included in the continued coverage.

The amount of the continued coverage will be reduced or terminated according to the Scheduled Benefit in force on the date your employment ends.

### Termination of Continued Coverage

Your coverage under this section will terminate on the earliest of:

- the premium due date coinciding with or next following the date the Group Policy terminates; or

- the date ending the period for which your last premium is paid for your insurance; or

- the January 1 next following your 75th birthday; or

- the date you become reemployed as a Full-Time Employee of the Policyholder.

**Individual Purchase Rights for Members**

- **Individual Policy**

  If you qualify and make timely application, you may convert the group coverage by purchasing an individual policy of life insurance under these terms:

  - You will not be required to submit Proof of Good Health.
  - The policy will be for life insurance only. No disability or other benefits will be included.
  - The policy will be on one of the forms, other than term insurance, then issued by Us to persons in the risk class to which you belong on the individual policy's effective date.
  - Premium will be based on your age and Our standard rate for the policy form to be issued.

- **Purchase Qualification**

  You will qualify for individual purchase at any time during the continuation period if your coverage which has been continued under this section terminates.

- **Application/Effective Date**

  Notice of the Individual Purchase Right must be given to you by Us before coverage under the Group Policy terminates, or as soon as reasonably possible thereafter.

  You must apply for individual purchase and the first premium for the individual policy must be paid to Us within 31 days after the date your coverage terminates under the Group Policy.

  Any individual policy issued will then be in force on the 32nd day after such termination date.

- **Individual Policy Amount**

  The amount of insurance that you may purchase will be your Member Life Insurance amount in force on the date of termination of the continued insurance or termination of the Group Policy, less any Accelerated Benefit payment and Accumulated Interest

Charges less the amount for which you become eligible under any group policy within 45 days.

**Dependent Life Insurance**

**Eligibility**

You will be eligible to continue your Dependent Life Insurance under this Portability feature on the date you are eligible to continue your Member Life Insurance.

**Amount of Continued Dependent's Coverage**

The maximum amount of Dependent Life Insurance you may continue for your Dependents is the amount of Dependent Life Insurance in force for such Dependents on the date your employment ends. You may continue any lesser amount for your Dependent spouse or Domestic Partner in increments of $10,000. You may not at any time increase the amount of Dependent Life Insurance which has been continued under this section.

In no event will your Dependent's Scheduled Benefit be more than 100% of your Scheduled Benefit amount, not to exceed $10,000 for a Dependent Child.

The amount of your continued Dependent coverage will be reduced or terminated according to the Scheduled Benefit in force on the date your employment ends.

**Termination of Continued Dependent Coverage**

Your coverage under this section for a Dependent will terminate on the earliest of:

- the premium due date coinciding with or next following the date the Group Policy terminates; or
- the date ending the period for which the last premium is paid for your Dependent's coverage; or
- the January 1 next following your spouse's or Domestic Partner's 75th birthday; or
- the date you become reemployed as a Full-Time Employee of the Policyholder; or
- the date your Member Life Insurance under this section ends; or
- the date your spouse or Domestic Partner or Dependent Child ceases to be a Dependent as defined in PART I.

**Individual Purchase Rights for Dependents Life Insurance**

- **Individual Policy**

If your Dependent qualifies and makes timely application, he or she may convert the group coverage by purchasing an individual policy of life insurance under these terms:

- The Dependent will not be required to submit Proof of Good Health.

- The policy will be for life insurance only. No disability or other benefits will be included.

- The policy will be on one of the forms, other than term insurance, then issued by Us to persons in the risk class to which the Dependent belongs on the individual policy's effective date.

- Premium will be based on the Dependent's age and Our standard rate for the policy form to be issued.

- **Purchase Qualification**

  A Dependent will qualify for individual purchase at any time during the continuation period if insurance which has been continued under this section terminates.

- **Application/Effective Date**

  Notice of the Individual Purchase Right must be given to you by Us before coverage under the Group Policy terminates, or as soon as reasonably possible thereafter.

  A Dependent must apply for individual purchase and the first premium for the individual policy must be paid to Us within 31 days after the date coverage terminates under the Group Policy.

  Any individual policy issued will then be in force on the 32nd day after such termination date.

- **Individual Policy Amount**

  The amount of insurance that a Member may purchase will be the Dependent Life Insurance benefit in force for the Dependent on the date of termination of the continued insurance or termination of the Group Policy, less the amount for which the Dependent becomes eligible under any group policy within 45 days.

**Application/Effective Date**

Notice of the Portability option must be given to you by the Policyholder before coverage under the Group Policy terminates, or as soon as reasonably possible thereafter.

You must apply and pay the first premium for the continued coverage within 31 days after you become eligible for the Portability option.

Any continued coverage under the Portability option will be in force on the 32nd day after such termination date.

**Payment Responsibility; Due Dates; Grace Period**

You agree to send all premium due to Our home office in Des Moines, Iowa, while coverage under this section of the Group Policy is in force.

Premiums are due in advance on the first day of each Premium Period. Premiums will be billed directly to you by Us. "Premium Period" means a monthly basis.

Premium payments must be made within 31 days after a due date. A Grace Period of 31 days will be allowed for payment of premium. "Grace Period" means the first 31-day period following a premium due date. Continued coverage will remain in force until the end of the Grace Period, unless the Group Policy has been terminated. You remain liable for submitting premium due for the time coverage remains in force during the Grace Period.

Your continued coverage will terminate, without notice, at the end of a Grace Period if your total premium due has not been received by Us before the end of the Grace Period. Failure by you to pay the premium within the Grace Period will be deemed notice by you to Us to discontinue continued coverage under the Group Policy at the end of the Grace Period.

**Administrative Fee**

We may charge you a monthly administration fee which will be shown on the Scheduled Benefits Summary.

**Our Responsibility to Members**

If the Group Policy terminates for any reason, We must:

- notify you of the effective date of the termination; and

- refund all premium contributions received from you for any Premium Period after the effective date of termination.

# CLAIM PROCEDURES

## Notice of Claim

Written notice of claim must be given to Us within 20 days after the date of loss. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

## Claim Forms

Claim forms and other information needed to prove loss must be filed with Us in order to obtain payment of benefits. The Policyholder will provide forms to assist you in filing claims. If the forms are not provided within 15 days after We receive such notice, you will be considered to have complied with the requirements of the policy upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character and extent of the loss.

## Proof of Loss

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Failure to give proof within the time specified will not invalidate or reduce any claim if proof is given as soon as reasonably possible. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

## Payment, Denial, and Review

The Employee Retirement Income Security Act (ERISA) permits up to 90 days for processing claims and up to 60 days for the review of denied claims.

In actual practice, benefits will be payable sooner, provided We receive complete and proper proof of loss. Furthermore, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for Our denial.

A Claimant may request a review of a claim denial by written request to Us within 120 days of receipt of notice of the denial. The Claimant must provide all additional information to Us within one year of receipt of notice of denial. We will notify the Claimant of the final decision and reasons in support of Our decision.

For purposes of this section, "Claimant" means you, your Dependent or Beneficiary.

## Medical Examinations

We may have you or your Dependent whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

**Autopsy**

If payment for loss of life is claimed, We may make a reasonable request for an autopsy where permitted by law. Our request will clearly set forth the reasons why an autopsy is warranted. We will pay for any such autopsy.

**Time Limits**

All time limits listed in this section will be adjusted as required by law.

**NOTE:** For additional Claims Procedures information, see GH 198 ERISA Claims.

## DEFINITIONS

Several words and phrases used to describe your coverage are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

**Active Work; Actively at Work** mean the active performance of all of your normal job duties at the Policyholder's usual place or places of business.

**Basic Annual Compensation** means, on any date, your basic annual (or annual equivalent) wage then in force, as established by the Policyholder. Basic wage does not include commissions, bonuses, tips or overtime pay. Basic wage does include any deferred earnings under a qualified deferred compensation plan and any amount of voluntary earnings reduction under a qualified Section 125 Cafeteria Plan.

**Dependent** means:

- Your spouse, if your spouse:
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member.
- Your Dependent Child (or Children) as defined below.
- Your Domestic Partner, if you and your Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Us.

Dependent will also include any person described above who elects to continue coverage under the Portability provisions described on GH 304.

**Dependent Child; Dependent Children** means:

- Your natural or legally adopted child, if that child:
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is less than 27 years of age, but through the end of the calendar year in which the child attains age 26.

  An adopted child will be considered a Dependent on the date of the judicial decree of adoption.
- Your stepchild, if that child:
  - meets the requirements above; and

- receives principal support from you and request for insurance includes the signature of the biological parent.

- Your Domestic Partner's child who otherwise qualifies above or if you or your Domestic Partner are the child's guardian by court order.

**Developmental Disability** means a Dependent Child's substantial handicap, as determined by Us, which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and

- is diagnosed by a Physician as a permanent or long-term continuing condition.

**Domestic Partner** means your same sex life partner, provided:

- your partner is not insured under the Group Policy as a Member; and

- your partner is at least 18 years of age; and

- neither your partner nor you are married; and

- neither your partner nor you have had another Domestic Partner in the six month period preceding the date of the Signed Declaration of Domestic Partnership; and

- your partner is not your blood relative; and

- your partner and you have shared the same residence or at least six consecutive months and continue to do so (proof of driver's license, tax return or other sufficient proof); and

- your partner and you are each other's sole life partner and intend to remain so indefinitely; and

- your partner and you are jointly responsible for each other's financial welfare providing evidence of two or more of the following:

  - a joint bank account;
  - a joint credit or charge card;
  - joint obligation on a loan
  - status as authorized signatory on the partner's bank account, credit card or charge card;
  - joint ownership or holding of investments;
  - joint ownership of residence;
  - joint ownership of real estate other than residence;
  - listing of both partners as tenants on the lease of the shared residence;

- shared rental payments of residence (need not be shared 50/50);
- listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- a common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- shared household budget for purposes of receiving government benefits;
- status of one as representative payee for the other's government benefits;
- joint ownership of major items of personal property (e.g., appliances, furniture);
- joint ownership of a motor vehicle;
- joint responsibility for child care (e.g., school documents, guardianship);
- shared child-care expenses, e.g., baby sitting, day care, school bills (need not be shared 50/50);
- execution of wills naming each other as executor and/or beneficiary;
- designation as beneficiary under the other's life insurance policy;
- designation as beneficiary under the other's retirement benefits account;
- mutual grant of durable power of attorney;
- mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- affidavit by creditor or other individual able to testify to partner's financial interdependence;
- other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case; and

- your partner and you are not in the relationship solely for the purpose of obtaining insurance coverage.

**Full Time Employee** means any person who is regularly scheduled to work for the Policyholder for at least 17.5 hours a week or a 50% full-time equivalent. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

**Group Policy** means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members and Dependents.

**Hospital** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

**Insurance Month** means calendar month.

**For All Registered Nurses Part of NYSNA:**

**Member** means any PERSON who is a Full-Time Employee of the Policyholder.

Member will also include any such person who elects to continue coverage under the Portability provisions described on GH 304.

**For All Other Active Members:**

**Member** means any PERSON who is a Full-Time Employee of the Policyholder who elected a Group Basic Life Scheduled Benefit amount equal to 1 times their Basic Annual Compensation.

Member will also include any such person who elects to continue coverage under the Portability provisions described on GH 304.

**Period of Limited Activity** means any period of time during which a person is:

- Confined in a Hospital for any cause or confined in a Skilled Nursing Facility; or

- Home Confined. "Home Confined" means that, due to sickness or injury, the person is unable to carry on the regular and usual activities of a healthy person of the same age and sex and unable to leave his or her home except to receive medical treatment.

**Physical Handicap** means a Dependent Child's substantial physical or mental impairment, as determined by Us, which:

- results from injury, accident, congenital defect or sickness; and

- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

**Physician** means a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.).

**Policyholder** means MONTEFIORE MEDICAL CENTER and shall include any affiliate or subsidiary of the Policyholder participating under the Group Policy.

**Prior Plan** means the group life insurance coverage of the Policyholder for which the Group Policy is a replacement.

**Proof of Good Health** means written evidence that a person is insurable under Our underwriting standards. This proof must be provided in a form satisfactory to Us.

**Scheduled Benefits Summary** means the page which is issued as part of your certificate which contains benefits and other information pertaining to your coverage under the Group Policy.

**Skilled Nursing Facility**

An institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.) ; and

- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and

- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and

- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places for treatment of mental disease, drug addiction, or alcoholism.

**Total Disability; Totally Disabled** means for you, your inability, as determined by Us, due to sickness or injury, to engage in any occupation for wage or profit.

**Total and Permanent Disability** means, because of sickness or injury, you are not able to engage in any occupation for wage or profit for a continuous period of one year.

**We, Us, and Our** mean Principal Life Insurance Company, Des Moines, Iowa.

**Principal Life Insurance Company**
**Des Moines, IA 50392-0002**

## STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

### Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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.

### Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require

the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

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

**Principal Life Insurance Company**
**Des Moines, IA 50392-0002**

# SUPPLEMENT TO YOUR BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Policyholders may use this booklet-certificate in part in meeting Summary Plan Description requirements under ERISA.

1. **Employer Plan Identification Number:**

   EIN: 13-1740114
   PN: 508

2. **Type of Administration:**

   Life Insurance Contract.

3. **Plan Administrator:**

   MONTEFIORE MEDICAL CENTER
   111 EAST 210TH STREET
   BRONX NY 10467

   See your employer for the business telephone number of the Plan Administrator.

4. **Plan Sponsor:**

   MONTEFIORE MEDICAL CENTER
   111 EAST 210TH STREET
   BRONX NY 10467

5. **Agent for Service of Legal Process:**

   MONTEFIORE MEDICAL CENTER
   111 EAST 210TH STREET
   BRONX NY 10467

   Legal process may also be served upon the plan administrator.

6. **Type of Participants Covered Under the Plan:**

   All active full-time employees of MONTEFIORE MEDICAL CENTER, and provided you are a Member as defined in the DEFINITIONS Section of this booklet (page GH 136 A).

7. **Sources and Methods of Contributions to the Plan:**

   Employee pays all of employee's contribution.

   Employee pays all of Dependent's contribution (if employee elects to enroll Dependents in plan).

8. **Ending Date of Plan's Fiscal Year:**

   December 31

**Principal Life Insurance Company**
**Des Moines, IA 50392-0002**

# BOOKLET-CERTIFICATE RIDER

**Subject: Employee Retirement Income Security Act (ERISA) Claims Procedures for Life, STD and LTD Insurance (Effective January 1, 2002)**

The provisions described below will replace the provisions described in your booklet-certificate.

The Department of Labor has promulgated regulations regarding claims procedure requirements. If your plan of benefits includes Life, STD and/or LTD, the Claims Procedures section of your group booklet-certificate has been changed to comply with the above referenced regulation.

Note: Changes have been made only to reflect the requirements of the ERISA. Any special state requirements relating to payment of claims remain unchanged unless they prevent the application of the ERISA requirements.

## CLAIM PROCEDURES

### Notice of Claim

Written notice of claim must be given to Us within 20 days (3 months for LTD) after the date of loss for which claim is being made. Failure to give notice within the time specified will not invalidate or reduce any claim if notice is given as soon as reasonably possible.

### Claim Forms

Claim forms and other information needed to provide proof of loss must be filed with Us in order to obtain payment of benefits. The Employer will provide appropriate claim forms to assist you in filing claims. If the forms are not provided within 15 days after We receive notice of claim, you will be considered to have complied with the requirements of the Group Policy regarding proof of loss upon submitting, within the time specified below for filing proof of loss, written proof covering the occurrence, character and extent of the loss.

### Proof of Loss

For Life Insurance booklet-certificates

Claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employee Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the appropriate claim form is received by Us.

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**Des Moines, IA 50392-0002**

For STD and LTD Insurance policies

Claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after you complete your Elimination Period. (For Long Term Disability Insurance, written proof that Disability exists and has been continuous must be sent to Us within six months after you complete your Elimination Period.) Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim. For purposes of satisfying the claims processing timing requirements of the Employment Retirement Income Security Act (ERISA), receipt of claim will be considered to be met when the Elimination Period has been completed and the appropriate claim form is received by Us.

**Payment, Denial, and Review**

ERISA permits up to 45 days from receipt of claim for processing the claim. If a claim cannot be processed due to incomplete information, We will send a written explanation prior to the expiration of the 45 days. A claimant is then allowed up to 45 days to provide all additional information requested. We are permitted two 30-day extensions for processing an incomplete claim. Written notification will be sent to a claimant regarding the extension.

In actual practice, benefits will be payable sooner, provided We receive complete and proper proof of loss. Furthermore, if a claim is not payable or cannot be processed, We will submit a detailed explanation of the basis for Our denial.

A claimant may request an appeal of a claim denial by written request to Us within 180 days of receipt of notice of the denial. We will make a full and fair review of the claim. We may require additional information to make the review. We will notify a claimant in writing of the appeal decision within 45 days after receipt of the appeal request. If the appeal cannot be processed within the 45-day period because We did not receive the requested additional information, We are permitted a 45-day extension for the review. Written notification will be sent to a claimant regarding the extension. After exhaustion of the formal appeal process, the claimant may request an additional appeal. However, this appeal is voluntary and does not need to be filed before asserting rights to legal action.

For purposes of this section, for Life insurance policies, “claimant” means you, your Dependent or beneficiary. For STD and LTD insurance policies, “claimant” means you.

**Legal Action**

Legal action with respect to a claim may not be started earlier than 90 days after proof of loss is filed and before the appeal procedures have been exhausted. Further, no legal action may be started later than three years after proof is required to be filed.

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**Des Moines, IA 50392-0002**

Please keep this rider with your booklet-certificate(s). Your booklet-certificate(s) will be updated sometime in the future to incorporate these provisions.

Nothing in this rider will vary, alter, or extend any provision or condition of the group policy(ies) other than as stated in this rider.

PRINCIPAL LIFE INSURANCE COMPANY
DES MOINES, IOWA 50392-0002

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**PLAN ARRANGED BY**

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12/01/2015

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