



# **GROUP BENEFIT PLAN**

**Geneva Medical Center - Union Employees**



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**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
Hartford, Connecticut  
(Herein called Hartford Life)

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**CERTIFICATE OF INSURANCE**

Under  
**The Group Insurance Policy**  
As of the  
**Effective Date**  
Issued by  
**HARTFORD LIFE**  
to  
**The Policyholder**

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This is to certify that We have issued and delivered the Group Insurance Policy (Policy) to the Policyholder. The Policy insures the Policyholder's employees who:

- are eligible for the insurance;
- become insured; and
- continue to be insured,

according to the terms of the Policy.

The terms of the Policy which affect an employee's insurance are summarized in the following pages.

This Certificate of Insurance, and the following pages, will become Your Booklet-certificate. The Booklet-certificate is a part of the Policy. This Booklet-certificate replaces any other which We may have issued to the Policyholder to give to You under the Policy specified herein.

**Richard G. Costello, Secretary**

**John C. Walters, President**

Some of the terms used within this Booklet-certificate are capitalized and have special meanings. Please refer to the definitions at the end of this Booklet-certificate when reading about Your benefits.

## **SCHEDULE OF INSURANCE**

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

The Policyholder: UNIVERSITY HOSPITALS HEALTH SYSTEM

The Policy Number: GL-044252

Policy Effective Date: July 1, 1998

**THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF SEPTEMBER 1, 2009.**

Anniversary Date: January 1 of each year, beginning in 2004.

### **Who is eligible for coverage?**

Eligible Class(es): All Active Full-time and Part-time Employees of Geneva Medical Center who are subject to a collective bargaining agreement and who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees

### **When will You become eligible? (Eligibility Waiting Period)**

You will be eligible for coverage on the date on which You complete a waiting period of 90 days of continuous active service.

The waiting period will be reduced by the period of time You were an Active Full-time or Part-time Employee with the Employer under the Prior Plan or by a period of time, granted as seniority, within the University Hospitals system.

### **When will You become eligible for Dependent Coverage?**

You will become eligible for Dependent coverage on the later of:

1. the date You become eligible for employee coverage; or
2. the date You acquire Your first Dependent.

### **What is the Guaranteed Issue Amount?**

This is the Amount of Insurance for which We do not require Evidence of Good Health. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

### **What is Evidence of Good Health?**

Evidence of Good Health is information about a person's health from which We can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by Us.

Inquiries as to the status of Your submission of Evidence of Good Health should be addressed to Your Employer and/or Benefit Administrator. We, Your Employer and/or Benefit Administrator will notify You of approvals. We will notify You, in writing, of any disapprovals.

**When will Evidence of Good Health be required?**

Evidence of Good Health is required if:

1. You enroll for coverage for Yourself more than 30 days after the date You are first eligible to do so; or
2. You elect no coverage for Yourself when eligible to do so and later opt for coverage.

Evidence of Good Health must be provided at Your own expense.

If Evidence of Good Health is not approved in the situation(s) described above, no coverage, including the Guaranteed Issue Amount, will become effective.

Evidence of Good Health is also required if You elect to increase coverage for Yourself by more than one option or increment level, provided You do not exceed the Guarantee Issue Amount.

Evidence of Good Health is also required the first time Your Amount of Life Insurance would exceed the Guaranteed Issue Amount for any coverage.

If Your Amount of Life Insurance is based on a multiple of Earnings, You must provide Evidence of Insurability if Your Earnings increase is such that Your Amount of Life Insurance is greater than the Guaranteed Issue Amount.

If Evidence of Good Health is not approved in this situation, You are eligible for the amount You requested for which Evidence of Good Health was not required.

However, if:

1. You do not submit Evidence of Good Health; or
2. Your Evidence of Good Health is not approved,

Your Amount of Life Insurance:

1. will increase, but only up to the amount for which You were eligible without having to provide Evidence of Good Health; and
2. will not increase again, or beyond that amount, until Your Evidence of Good Health is approved.

Additionally, once approved, Evidence of Good Health will be required again only if Your or Your Dependents Amount of Life Insurance is greater than the Guarantee Issue Amount and You increase Your or Your Dependents coverage election.

**AMOUNT OF LIFE INSURANCE  
Employee Only**

**What Life benefits are available to You?**

**Basic Amount of Life Insurance:**

- a) a Guaranteed Issue Amount equal to 2 times Your annual rate of basic Earnings, subject to a maximum of \$800,000 without Evidence of Good Health; or
  - b) a maximum amount equal to 2 times Your annual rate of basic Earnings, subject to a maximum of \$2,000,000 with Evidence of Good Health,
- rounded to the next higher multiple of \$1,000, if not already such a multiple.

**Supplemental Amount of Life Insurance:**

(Please see Your Booklet-certificate endorsement)

## **REDUCED AMOUNTS OF INSURANCE**

Your Amount of Life Insurance will decrease by 35% on the Anniversary Date which occurs on or next follows the date You attain age 65 and by 50% when You attain age 70. The reduction will apply to the Amount of Life Insurance in force immediately prior to the first reduction made.

Additionally, if:

1. You become insured under the Policy; or
2. Your coverage increases,

on or after the date You attain age 65, We reduce the amount of coverage for which You would otherwise be eligible in the same manner.

Reduced amounts of Life Insurance will be rounded to the next higher multiple of \$500, if not already such a multiple.

## **AMOUNT OF LIFE INSURANCE Dependent Only**

### **What Life benefits are available to Your Dependents?**

#### **Option 1:**

##### **Dependent Spouse:**

An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$30,000.

##### **Dependent Children:**

No Coverage

#### **Option 2:**

##### **Dependent Spouse:**

An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$10,000.

##### **Dependent Children:**

No Coverage.

#### **Option 3:**

##### **Dependent Spouse:**

An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$30,000.

##### **Dependent Children:**

less than 14 day(s) of age: No Coverage.

14 day(s) but less than 6 month(s) of age: \$500

6 month(s) of age or older: An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$10,000.

#### **Option 4:**

##### **Dependent Spouse:**

An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$10,000.

**Dependent Children:**

less than 14 day(s) of age:	No Coverage.
14 day(s) but less than 6 month(s) of age:	\$500
6 month(s) of age or older:	An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$10,000.

**Option 5:**

**Dependent Spouse:**

An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$5,000.

**Dependent Children:**

less than 14 day(s) of age:	No Coverage.
14 day(s) but less than 6 month(s) of age:	\$500
6 month(s) of age or older:	An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$5,000.

**Option 6:**

**Dependent Spouse:**

No Coverage.

**Dependent Children:**

less than 14 day(s) of age:	No Coverage.
14 day(s) but less than 6 month(s) of age:	\$500
6 month(s) of age or older:	An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$10,000.

**Option 7:**

**Dependent Spouse:**

No Coverage.

**Dependent Children:**

less than 14 day(s) of age:	No Coverage.
14 day(s) but less than 6 month(s) of age:	\$500
6 month(s) of age or older:	An amount equal to the lesser of 50% of the employee's Basic Amount of Life Insurance or \$5,000.

**ELIGIBILITY AND ENROLLMENT**

**Must You contribute toward the cost of coverage?**

With respect to Basic Life Insurance coverage, You do not contribute toward the cost.

With respect to Supplemental Life Insurance and Dependent Life Insurance coverage, You must contribute toward the cost.

**How do You enroll?**

Eligible Persons have the option to enroll electronically. Your Employer will provide instructions.

With regard to new hires, You must enroll within 30 days of the date You have completed the Employer's orientation program.

If You do not enroll within 30 days after becoming eligible, the following limitations will apply to a later enrollment:

1. You must submit Evidence of Good Health; and
2. You may not enroll until:
  - a) an Annual Enrollment Period; or
  - b) You have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 30 days of the Change in Family Status.

The Annual Enrollment Period is determined by Your Employer on a yearly basis.

If You are not required to contribute toward the cost of coverage, You are not required to request coverage. Enrollment will be automatic. However, You will be required to complete a beneficiary election form.

**What constitutes a Change in Family Status?**

A Change in Family Status means:

1. Your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
2. the death of or divorce from Your spouse;
3. the death of or emancipation of a child;
4. spouse's loss of employment which results in a loss of group insurance; or
5. change in classification from Part-time to Full-time or from Full-time to Part-time.

**When does coverage start?**

Your coverage will start on the latest of the dates determined below:

1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 30 days after the date You are eligible;
3. the date We approve Evidence of Good Health which We may have required; or
4. the January 1<sup>st</sup> of the next calendar year following the Annual Enrollment Period if You enroll during an Annual Enrollment Period.

All of the above effective dates are subject to the Deferred Effective Date provision.

**What is the Deferred Effective Date provision for employees?**

If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time or Part-time Employee.

**Are there exceptions to the Deferred Effective Date provision?**

If You were actively at work or on an approved leave of absence in conformity with the Family or Medical Leave Act of 1993, and insured under the Prior Plan on the day before the Policy Effective Date and You would be eligible for coverage on the Policy Effective Date except that You are not able to meet the requirements of the Deferred Effective Date provision, then:

1. the Deferred Effective Date provision will not apply to the original effective date of coverage; and
2. the coverage amount shown in the Schedule of Insurance will not apply to You.

Instead, You will be considered to be insured and Your coverage amount will be the lesser of:

1. the Amount of Life Insurance under the Prior Plan; or
2. the Amount of Life Insurance shown in the Schedule of Insurance,

reduced by:

1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

You will remain insured under this provision until the first to occur of:

1. the date You return to work as an Active Full-time or Part-time Employee;
2. the date Your insurance terminates for a reason stated under the Termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day You would have been covered under the Prior Plan, had the Prior Plan not terminated.

#### **When does coverage for Your Dependent(s) start?**

You are required to enroll for contributory Dependent coverage. To do so You have to complete and sign a group insurance enrollment form acceptable to Us and deliver it to the Employer.

Your spouse will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for spouse coverage by then; or
2. the date You enroll for Dependent Coverage, if You do so within 31 days after the date You are eligible.

Each child will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for child coverage by then; or
2. the date You enroll for coverage for Your child, if You do so within 31 days after the date You acquire the child.

In no event will Dependent Coverage become effective before the date You become insured.

All effective dates of coverage are subject to the Deferred Effective Date provision for Dependents.

#### **What is the Deferred Effective Date provision for Dependents?**

If a Dependent, other than a newborn, is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of insurance, any increase or additional benefit will be deferred until the Dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

"Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

#### **Are there exceptions to the Deferred Effective Date provision?**

If You were insured with respect to a Dependent under the Prior Plan as of the day before the Policy Effective Date, the Deferred Effective Date provision will not apply to the original effective date of coverage for any Dependent.

Instead, Your Dependent will be considered to be insured and the Amount of Insurance will be the lesser of:

1. the Amount of Insurance in force on the life of the Dependent under the Prior Plan; or
2. the Amount of Insurance shown in the Schedule of Insurance.

#### **When are changes effective?**

The provisions, terms and conditions of the Schedule of Insurance or this Booklet-certificate may be modified, amended or changed at any time; consent from any covered individual is not required.

If there is any type of change in Your class, Earnings, the Schedule of Insurance or the Booklet-certificate which:

1. decreases an amount of coverage or deletes, limits or restricts the availability of a benefit or provision, then that decrease, deletion, limitation or restriction will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective;
2. increases an amount of coverage or adds, improves or increases availability of a benefit or provision, then that increase, addition or improvement will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective, subject to application of the Deferred Effective Date provision and Our approval where Evidence of Good Health is required.

## **BENEFITS**

### **Life Insurance Benefit**

#### **To whom and how are benefits paid?**

A completed claim form, a certified copy of the death certificate and Your enrollment form must be sent to the Employer or Us. When the required claim papers are received and approved by Us, the Amount of Life Insurance will be paid.

Benefits payable for a Dependent's death are payable to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by You in writing and on file with the Employer.

Unless You have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1. up to \$500 of Your life insurance to any party that We deem is entitled because of their payment of burial expenses. We will be released from further liability for any amount so paid; and/or
2. the executors or administrators of Your estate; or
3. Your surviving relatives in the following order:
  - a) all to Your surviving spouse; or
  - b) if Your spouse does not survive You, in equal shares to Your surviving children; or
  - c) if no child survives You, in equal shares to Your surviving parents.

If a minor does not have a legal guardian, We may, until such a guardian is appointed, pay the person We deem to be caring for and supporting him. Such payment will be in monthly installments of not more than \$200.

If a death benefit payable meets Our guidelines, then the benefit is payable into a checking account. In the case of a Dependent death benefit, You own the checking account. In the case of Your death benefit, Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

#### **What benefit is payable if Your death results from suicide?**

No Supplemental Life benefit will be payable if death results from suicide, whether sane or insane, within 2 years of the effective date of Your coverage. Additionally, if death resulting from suicide, whether sane or insane, occurs within 2 years of the effective date of an increase in Your coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 2 year period includes the time coverage was in force under a Prior Plan.

## **Accelerated Death Benefit**

**This benefit is not available for Dependents.**

### **What is the benefit?**

If You are diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and You are:

1. less than age 60; and
2. insured for at least \$10,000,

then You may request that a portion of Your Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of \$3,000 and a maximum of \$500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to \$20,000 and You are Terminally Ill, You can request any portion of the life insurance between \$3,000 to \$16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only \$3,000 now, You cannot request the additional \$13,000 in the future.

### **What does Terminal Illness/Terminally Ill mean?**

Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

**RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.**

### **What if an individual is no longer Terminally Ill?**

If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

**RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.**

### **What if an individual is no longer Terminally Ill?**

If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

### **What limitations apply to this benefit?**

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

### **What if You made an assignment under this plan?**

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

## **TERMINATION Employee Coverage**

### **When does Your coverage terminate?**

Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:

1. the date the Policy terminates;
2. the last day of the period for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the date Your Employer terminates Your employment; or
5. the date You are absent from work as an Active Full-time or Part-time Employee.

## **EXCEPTIONS TO TERMINATION**

### **Under what conditions can Your insurance be continued under the continuation provisions?**

If You are absent from work as an Active Full-time or Part-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:

1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are on a documented leave of absence, other than Family or Medical Leave, all of Your coverages (including Dependent Life coverage) may be continued for 30 consecutive day(s) following the month in which the leave of absence commenced.

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, all of Your coverages (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your insurance would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level will be that which was in effect on the day before said leave started, subject to any reductions included in the Policy;
4. the amount of Earnings upon which Your benefit may be based, will be that which was in effect on the day before said leave started; and
5. continued coverage will cease immediately if one of the following events should occur:
  - a) the leave terminates prior to the agreed upon date;
  - b) the Policy terminates;
  - c) You or the Policyholder fail to pay premium when due; or
  - d) the Policy no longer insures Your class.

In all other respects, the terms of Your insurance remain unchanged.

If You are absent from work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time or Part-time Employee. If You feel that Your condition may continue for an extended period of time, You should request that Your Employer file a waiver of premium claim.

### **What is Waiver of Premium?**

Waiver of premium is a provision which allows for continued employee life insurance, without payment of premium, while You are Disabled.

**To what coverages does the Waiver of Premium apply?**

These provisions apply only to Your Basic and Supplemental Life Insurance.

Waiver of Premium does not apply to any Dependent Life Insurance.

**What conditions must be satisfied before You qualify for Waiver of Premium?**

1. You must be less than age 60, insured and Disabled; and
2. acceptable proof of Your condition must be furnished to Us within one year of Your last day of work as an Active Full-time or Part-time Employee.

**What does Disabled mean?**

Disabled means that You have a condition that prevents You from doing any work for which You are or could become qualified by education, training or experience and it is expected that this condition will last for at least six consecutive months from Your last day of work as an Active Full-time or Part-time Employee; or You have been diagnosed with a life expectancy of 12 months or less.

**When will We waive premium?**

We will waive premium after proof that You are Disabled is provided by an attending physician licensed to practice in the United States and We approve the proof. You will be notified by Us of the date We will begin to waive premium.

Continued coverage will be subject to any age reductions provided by any part of the Policy.

**What if You die before You qualify for Waiver of Premium?**

If:

1. You should die within one year of Your last day of work as an Active Full-time or Part-time Employee but prior to qualifying for waiver of premium; and
2. You were Disabled,

We will pay the Amount of Life Insurance which is in force for You.

**Can We have You examined for proof that You continue to be Disabled?**

During the first two years following the date You qualify as Disabled, We may have You examined at reasonable intervals. Thereafter, We will only require an annual examination to confirm that You continue to be Disabled. If You fail to submit any required proof or refuse to be examined as required by Us, then Your coverage will terminate.

**What if You are no longer Disabled?**

If, for any reason, You are no longer Disabled, Your premium will no longer be waived. On that date, You may or may not return to work.

If You return to work in an Eligible Class, then all of Your coverages will be reinstated subject to the terms of the Policy in effect on the reinstatement date.

If You do not return to work within an Eligible Class, and You are not eligible for any other group life insurance, then You are entitled to the Conversion Privilege. You may convert the Amount of Life Insurance that is in force for You on the date it is determined that You are no longer Disabled.

**How long will premiums be waived?**

Your premium will be waived and Your coverage will be continued until You attain age 65.

On the date waiver of premium terminates, if You do not return to work, You will be entitled to convert Your coverage. You may convert no more than Your Amount of Life Insurance that is in force on the date waiver of premium terminates.

**What if the Policy terminates before You qualify for waiver of premium?**

If the Policy terminates before You qualify for waiver of premium, You may be eligible to convert. Additionally, You may later be approved for waiver of premium.

**What if the Policy terminates after You qualify for waiver of premium?**

Termination of the Policy will not affect Your coverage under the terms of this provision.

**DEPENDENT COVERAGE**

**When does Dependent Coverage terminate?**

Unless continued in accordance with the Exception to Termination section, a covered Dependent's insurance will terminate on the earliest of:

1. the date Your coverage terminates;
2. the last day of the period for which any required premium contribution is made, if You fail to make any further required contribution;
3. the date You are no longer eligible for Dependent Coverage;
4. the date the Dependent no longer meets the definition of Dependent; or
5. the date We or the Employer terminate Dependent Coverage.

**EXCEPTIONS TO TERMINATION**

**Under what conditions can Dependent child insurance be continued?**

If a covered Dependent child reaches the age at which He would otherwise cease to be a Dependent as defined, and the Dependent child is:

1. disabled and incapable of earning His own living; and
2. unmarried and primarily dependent on You for support and maintenance,

then Dependent coverage will not terminate solely due to age if You submit satisfactory proof of the Dependent child's disability to Us within 31 days of the date the Dependent child reaches such age.

Coverage will continue while the Policy remains in force as long as:

1. the child continues to meet the required conditions; and
2. any required premium is paid.

We will have the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two years of continuation, but not more than once a year after that.

**CONVERSION PRIVILEGE**

**When can an individual convert?**

If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

If the qualifying event is policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy in order to be eligible for this conversion privilege.

**What is the conversion policy?**

The conversion policy will:

1. be on one of the life insurance policy forms, except term insurance, then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

**How much can be converted?**

If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:

1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage; or
2. \$10,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

**How does an individual convert coverage?**

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to the Us and pay the premium required for his age and class of risk.

The individual will be given notice of the conversion privilege at least 15 days prior to the expiration of the 31-day conversion period. If such notice is not given, the individual will have an additional period in which to exercise conversion rights. This additional period will extend for 15 days after the individual is given notice; but in no event will the period extend beyond 60 days after the expiration date provided in the Policy. Written notice of conversion will be presented to the individual or mailed by the Employer or Us to the last known address.

**What if death occurs during the conversion election period?**

If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

**GENERAL PROVISIONS**

**When can this plan be contested?**

Except for non-payment of premium, the Policy cannot be contested after two years from the Policy Effective Date.

No statement relating to insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the individual's lifetime. In order to be used, the statement must be in writing and signed by the affected individual.

**Who interprets policy terms and conditions?**

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

**Are there any rights of assignment?**

You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:

1. the right to make any contributions required to keep the insurance in force;
2. the privilege of converting; and
3. the right to name and change a beneficiary.

No absolute assignment of rights and interest shall be binding on Us until and unless:

1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:

1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

**How do You designate or change Your beneficiary?**

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

**What recourse do You have if Your claim is denied?**

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
  - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
  - b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

**DEFINITIONS**

**Active Full-time or Part-time Employee** – An employee who works for the Employer on a regular basis in the usual course of the Employer's business. An employee must be scheduled for at least 16 hours in the Employer's normal work week. You will be considered actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a Full-time basis with respect to Full-time employees, or on a Part-time basis with respect to Part-time employees, on that day. You will also be considered actively at work on a paid vacation day or a day which is not one of Your Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

**Amount of Life Insurance** – This term means both the Basic and Supplemental Life Amounts unless otherwise stated in specific provisions and benefits.

**Dependent**

1. Your spouse; and
2. Your unmarried child:
  - a) from live birth to age 19 years; or
  - b) who is 19, but has not yet attained age 23, is primarily dependent upon You for financial support and attends an accredited school (other than a correspondence school) on a regular and Full-time student basis as his principal activity; or
  - c) who is 19 years old or older, and is disabled and primarily dependent upon You for financial support.

The term "Full-time student" shall mean registered for not less than 12 course credit hours per semester. If the institution establishes Full-time student status by a method other than semester credit hours, We reserve the right to determine whether the student qualifies as a Dependent.

The term "child", shall also include Your:

1. stepchild;
2. legally adopted child; and
3. any other child related to You by blood or marriage and who lives with You in a regular parent-child relationship, provided that You claim such child as a dependent on Your most current federal income tax return Form 1040.

You may not elect coverage for Your Dependent if Your Dependent is covered as an employee under the Policy. Any person who is in Full-time military, naval or air force service cannot be a Dependent. No person can be insured as a Dependent of more than one employee under the Policy.

**Earnings** - Regular pay, not counting:

1. commissions;
2. bonuses;
3. overtime pay; or
4. any other pay or fringe benefits.

**Employer** – The Policyholder named in the Schedule of Insurance.

**He/His** – He or she. His or her.

**Prior Plan** – A plan of group term life insurance sponsored by the Employer which was in force on the day before the Policy Effective Date.

**We/Us/Our** – The Hartford Life and Accident Insurance Company.

**You/Your** – The employee to whom this Booklet-certificate is issued.

## STATUTORY PROVISIONS

### CALIFORNIA

#### LIFE

The definition of Dependent is amended as follows

The term "spouse" means an individual who is either:

- a) in a marriage with the employee which is recognized by the law in the state of residence; or
- b) in a registered domestic partnership with the employee in accordance with California law.

Reference in this form to an employee's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

### NEW YORK

#### LIFE

The following provisions are applicable to residents of New York and are included to bring your Booklet-certificate into conformity with New York state law.

#### **1. Conversion Privilege**

The Conversion Privilege appearing in the Booklet-certificate is replaced with the following.

#### **CONVERSION PRIVILEGE**

##### **When can an individual convert?**

If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert His life insurance to a conversion policy without providing Evidence of Good Health.

##### **What is the conversion policy?**

The conversion policy will:

1. be on one of the life insurance policy forms then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

At the individual's option, the personal life policy may be preceded by a single-premium one year term insurance policy, subject to the same conditions. If Your insurance terminates due to Your total and permanent disability, You may elect any one of the life insurance policy forms then customarily issued by the Insurer, subject to the same conditions, at the end of the one year period.

The term "Insurer" means Us or any other insurance company which has agreed with Us to issue conversion policies according to this conversion privilege.

**How much can be converted?**

The amount which may be converted is limited to the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which You become covered within 31 days of termination of group coverage. If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

**How does an individual convert coverage?**

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to Us and pay the premium required for His age and class of risk.

If an individual is not given notice of the existence of the conversion privilege within 15 days of the terminating event which results in the conversion option, He will have an additional period in which to exercise conversion rights. This additional period will end 45 days following the date He is given notice of the right to convert or 90 days following the date on which the terminating event which results in the conversion option occurs, whichever occurs first. Written notice of conversion rights will be presented to the individual or mailed by the Employer or Us to the last known address.

**What if death occurs during the conversion election period?**

If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

**2. Accelerated Death Benefit**

This benefit is not available for Dependents.

**What is the benefit?**

If You are diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and You are:

1. less than Normal Retirement Age; and
2. insured for at least \$10,000;

then You may request that a portion of Your Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of the lesser of 25% of the in force Amount of Life Insurance or \$50,000, and a maximum of \$500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to \$20,000 and You are Terminally Ill, You can request any portion of the life insurance between \$5,000 to \$16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only \$5,000 now, You cannot request the additional \$11,000 in the future.

**What does Terminal Illness/Terminally Ill mean?**

Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

**RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.****What if an individual is no longer Terminally Ill?**

If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted. Any amount paid as an Accelerated Death Benefit is not available for conversion. Please see the Conversion Privilege section.

**What limitations apply to this benefit?**

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of this Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

**What if You made an assignment under this Policy?**

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

**3. Suicide**

The suicide provision is amended to read as follows.

**What benefit is payable if death results from suicide?**

No Supplemental Life benefit will be payable if death results from suicide within 2 years of the effective date of coverage. Additionally, if death resulting from suicide, occurs within 2 years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 2 year period includes the time coverage was in force under a Prior Plan.

**NORTH CAROLINA**

**LIFE**

The following provision is applicable to residents of North Carolina and is included to bring Your Booklet-certificate into conformity with North Carolina state law.

**Waiver of Premium**

We will refund the amount of any premium which have been paid to Us and to which it is determined that Waiver of Premium applies.

Certificate of Insurance

**HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY**  
Hartford, Connecticut



**Policyholder:** University Hospitals Health System

**Policy Number:** 45-ADD-S01122

**Policy Effective Date:** January 1, 2004

**Certificate Effective Date:** January 1, 2009

We have issued a policy to the Policyholder. Our name, the Policyholder name and the Policy Number are shown above. The provisions of the policy which are important to you are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to you earlier for the policy. The policy alone is the only contract under which payment will be made. Any difference between the policy and this Certificate will be settled according to the provisions of the policy.

**Richard G. Costello, Secretary**

**John C. Walters, President**

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**ACCIDENTAL DEATH & DISMEMBERMENT SCHEDULE**

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**Eligible Persons:**

All active full-time and part-time employees of Geneva Medical Center, who are subject to a collective bargaining agreement and working at least 16 hours weekly. Employees are eligible 90 days of continuous active service.

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**Mandatory Plan**

**Principal Sum:**

1 times Salary, rounded to the next highest \$1,000, to a Maximum Amount of \$2,000,000

**Voluntary Plan**

**Principal Sum:**

The Principal Sum applicable to you is the amount for which:

- a) you are eligible to request as determined below;
- b) you have given us a Written Request; and
- c) the required premium is paid.

**Principal Sum Amount:**

1, 2, 3, or 4 times Salary, rounded to the next highest \$1,000, to a Maximum Amount of \$2,000,000

In no event shall the combined amount of:

- o Mandatory Accidental Death & Dismemberment
  - o Voluntary Accidental Death & Dismemberment
- exceed \$2,000,000

**Salary** means your base annual salary on the date of the accident; excluding overtime pay, bonuses, commissions and any other type of incentives.

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**Form PA-5427 A2 (HLA) (ADD-S01122)**

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Printed in U.S.A.

**Eligible Dependents:** Eligible Person's Spouse and Child(ren)

**Policy Age Limit:** None

**Accidental Death and Dismemberment Reduction on and after Age 65:** On the January 1st on or next following your attainment of ages 65 and 70, your amount of Principal Sum will reduce. The reduced amount will be determined by multiplying the Amount of Principal Sum determined in the Enrollment Form on file with the Policyholder and applicable to you by the percentage shown below for your attained age, rounded to the next higher multiple of \$500, if not already such a multiple:

<b>Insured Person's Age</b>	<b>Percentage of Principal Sum</b>
Age 65-69	65%
Age 70 or over	50%

If you are age 65 or over you will not be eligible for a Principal Sum Amount that is more than the Percentage of Principal Sum shown above for your attained age.

**Principal Sum for Each of Your Eligible Dependents  
(Please see Accidental Death and Dismemberment Benefit)**

**Seat Belt Coverage (Insured Person Only)**

Seat Belt Benefit Amount: 10% of Principal Sum to a Maximum amount of \$25,000

**Coma Benefit (Insured Person only)**

Waiting Period: 30 days

**DEFINITIONS:** **We, us** or **our** means the insurance company named on the face page. **You, your** or **Insured Person** means an Eligible Person while he or she is covered under the policy. **Covered Person** means you or your Eligible Dependent while you, he or she is covered under the policy. **Injury** means bodily injury resulting directly from accident and independently of all other causes which occurs while the Covered Person is covered under the policy. Loss resulting from: a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or b) medical or surgical treatment of a sickness or disease; is not considered as resulting from Injury. **On**, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance. **Civil or Public Aircraft** means an aircraft which: a) has a current and valid Airworthiness Certificate; b) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and c) is not operated by the militia or armed forces of any state, national government or international authority. **Airworthiness Certificate** means: a) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration; or b) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry. **Military Transport Aircraft** means a transport aircraft operated by: a) the United States Air Mobility Command (AMC); or b) a national military air transport service of any country. **Written Request** means any form provided by us for the particular request.

**INSURED PERSONS PERIOD OF COVERAGE: Effective Date:** Your coverage becomes effective on the later of: a) the Policy Effective Date; or b) the 1st of the month coincident with or next following 90 days of continuous service. **Termination:** Your coverage as an Insured Person terminates on the earlier of: a) the date the policy is terminated; or b) the date you: a) cease to be an Eligible Person, or b) attain the Policy Age Limit, if any, shown in the Schedule **Request For Change In Coverage:** If you give us a Written Request for a change in your coverage, and if you: a) are not eligible for the coverage requested, the change will not become effective; b) are eligible for the coverage requested, the change will become effective on the date we receive the request.

**DEPENDENTS PERIOD OF COVERAGE:** You are insured with Dependents Coverage if you have any eligible dependents as defined below. **Eligibility:** Eligible Dependents are defined below. In any event, you are not an Eligible Dependent. Eligible Dependents: 1) Spouse means your spouse unless: a) you and your spouse are legally separated or divorced; or b) your spouse has attained the Policy Age Limit, if any, shown in the Schedule. 2) **Child** or **Children** means your unmarried child, stepchild, legally adopted child or foster child: a) who is less than age 19 and primarily dependent on you for support and maintenance; or b) who is at least age 19 but less than age 23 who: 1) regularly attends an institution of learning; and 2) is primarily dependent on you for support and maintenance.

**Effective Date:** Each Eligible Dependent will become covered under the policy on the later of: a) the date you become an Insured Person; the date We receive your Written Request for coverage of Dependents; or c) the date the person qualifies as an Eligible Dependent. **Termination:** Coverage of each Eligible Dependent terminates on the earliest of : a) the date you cease to be an Insured Person; or b) the date he or she ceases to qualify as an Eligible Dependent.

**Incapacitated Child:** Coverage of a child who, on the date he or she reaches age 19 or 23, is: a) covered under the policy; b) mentally or physically incapable of earning his or her own living; and c) unmarried and primarily dependent on you for support and maintenance; will not terminate solely due to age. However, you must give us notice of the incapacity within 31 days of the termination date. Coverage will continue as long as: a) the incapacity continues; and b) the required premium is paid. We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year. **Request for Change in Coverage:** If you give Us a Written Request for a change in the coverage of your Eligible Dependents, and if you: a) are not eligible for the coverage requested, it will not become effective; or b) are eligible for the coverage requested, the change will become effective on the date We receive the request.

**EXCLUSIONS:** The policy does not cover any loss resulting from: 1) intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane; 2) war or act of war, whether declared or undeclared; 3) Injury sustained while full-time in the armed forces of any country or international authority; 4) Injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft; 5) Injury sustained while riding On any aircraft: a) as a pilot, crewmember or student pilot; b) as a flight instructor or examiner; or c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under the policy; 6) Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician; 7) Injury sustained while operating a motor vehicle while legally intoxicated from the use of alcohol.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:** If a Covered Person's Injury results in any of the following losses within 365 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident. Your amount of the Principal Sum is determined in the Schedule. The amount of Principal Sum for each of your Covered Dependents is shown below as a percent of your Principal Sum.

		<b>Spouse</b>	<b>Each Child</b>
You with:*	Spouse only	60%	0%
	Spouse & Children	50%	10%
	Children only	0%	15%

\*As determined on the date of accident.

The Principal Sum for any one Child cannot exceed the lesser of the amount calculated above or \$50,000.

For Loss of:

Life .....	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes .....	The Principal Sum
One Hand and One Foot .....	The Principal Sum
Speech and Hearing .....	The Principal Sum
Either Hand or Foot and Sight of One Eye .....	The Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia) .....	The Principal Sum
Movement of Both Lower Limbs (Paraplegia) .....	Three-Quarters The Principal Sum
Movement of Both Upper and Lower Limbs of One Side of Body (Hemiplegia) .....	One-Half The Principal Sum
Either Hand or Foot .....	One-Half The Principal Sum
Sight of One Eye .....	One-Half The Principal Sum
Speech or Hearing .....	One-Half The Principal Sum
Thumb and Index Finger of Either Hand .....	One-Quarter The Principal Sum

**Loss** means with regard to: a) hands and feet, actual severance through or above wrist or ankle joints; b) sight, speech or hearing, entire and irrecoverable loss thereof; c) thumb and index finger, actual severance through or above the metacarpophalangeal joints; d) movement of limbs, complete and irreversible paralysis of such limbs.

**EXPOSURE:** Exposure to the elements will be presumed to be Injury if: a) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the Covered Person was an occupant at the time of the accident; and b) the policy would have covered Injury resulting from the accident. **DISAPPEARANCE:** A Covered Person will be presumed to have suffered loss of life if: a) his or her body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance; b) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and c) the policy would have covered Injury resulting from the accident.

**SEAT BELT COVERAGE:** If your Injury results in a covered Loss while: a) a passenger riding in; or b) the licensed operator of; a duly registered Automobile, and while wearing a Seat Belt at the time of Accident as verified on the police report, then the amount of the Principal Sum will be increased by the Seat Belt Benefit Amount stated in the Schedule. **Accident,** for the purpose of Seat Belt Coverage, means the unintentional collision of an Automobile during which you are wearing a Seat Belt. **Automobile** means a four-wheeled, private passenger car, station wagon, van or jeep-type vehicle which is not being used as a Common Carrier. **Common Carrier** means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern. **Seat Belt** means a belt, lap restraint, or shoulder restraint installed by the manufacturer of the Automobile. **Exclusions:** This Seat Belt Coverage does not cover any loss if you: a) are under the influence of any intoxicant, excitant, hallucinogen, or any narcotic or other drug, or similar substance as verified in the police accident report (unless administered under the advice of a physician); and b) are operating the Automobile.

**COMA BENEFIT:** If, as the result of an Injury, you: a) become Comatose within 31 days from the accident; and b) remain continuously Comatose for at least the number of days shown as the Waiting Period; we will pay 1% of the Comatose Maximum Benefit Amount for each month after the Waiting Period that you remain in a Coma. Payment will cease on the earliest to occur of: 1) the end of the month in which you die; 2) the end of the month in which you recover from the Coma; or 3) when the total payment equals the Comatose Maximum Benefit Amount. The Comatose Maximum Benefit Amount equals the Principal Sum less all other payments under the Accidental Death and Dismemberment Benefit for the Injury. **Coma** means complete and continuous a) unconsciousness; and b) inability to respond to external or internal stimuli. Your amount of the Principal Sum and Waiting Period are shown in the Schedule.

**CLAIMS: Notice of Claim:** The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include your name and the policy number. Send it to our office in Hartford, Connecticut, or give it to our agent. **Claim Forms:** When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us. **Proof of Loss:** Proof of loss must be sent to us in writing within 90 days after: a) the end of a period of our liability for periodic payment claims; or b) the date of the loss for all other claims. If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated. **Time of Claim Payment:** We will pay any daily, weekly or monthly benefit due: a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or b) immediately after we receive the proof of loss following the end of our liability. We will pay any other benefit due immediately after we receive the proof of loss.

**Payment of Claims:** We will pay any benefit due for loss of your life: a) according to the beneficiary designation in effect under the policy at the time of your death; otherwise b) if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at time of death; or c) to the survivors, in equal shares, in the first of the following classes to have a survivor at your death: 1) spouse, 2) children, 3) parents, 4) brothers and sisters. If there is no survivor in these classes, payment will be made to your estate. All other benefits due and not assigned will be paid to you, if living. Otherwise, the benefits will be paid according to the above. If a benefit due is payable to: a) your estate; or b) you or any person who is either a minor or not competent to give a valid release for the payment; we may pay up to \$1,000 of the amount to some other person. The other person will be someone related to the minor or the incompetent person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in

good faith. **Physical Examinations and Autopsy:** While a claim is pending we have the right at our expense: a) to have the person who has a loss examined by a physician when and as often as we feel is necessary; and b) to make an autopsy in case of death

where it is not forbidden by law. **Legal Actions:** You cannot take legal action against us: a) before 60 days following the date proof of loss is sent to us; b) after 3 years following the date proof of loss is due. **Naming a Beneficiary:** You may name a beneficiary or change a revocably named beneficiary by giving your Written Request to the Policyholder. Your request takes effect on the date you execute it, regardless of whether you are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment we made in good faith before the Policyholder received your request. **Assignment:** We will recognize any assignment you make under the policy, provided: a) it is duly executed; and b) a copy is on file with us. We and the Policyholder assume no responsibility for the validity or effect of an assignment.

## STATUTORY NOTICES

**For Residents of Arkansas: IMPORTANT NOTICE:** ARKANSAS INSURED'S ACCESS TO INSURER INFORMATION: This notice is to comply with Arkansas House Bill 1221. We are required by law to notify you of the complete addresses and phone numbers of the Arkansas Insurance Department, the insurance company's servicing office, and the agent. Below is this information: Arkansas Insurance Department, Consumer Services Division, 400 University Tower Building, Little Rock, Arkansas 72204, Telephone: 1-800-852-5494. Servicing Office: Hartford Life Insurance Company, Special Risk Life and Health Department, P.O. Box 2250, Alpharetta, GA 30023 Telephone: (770) 753-0085. If you have any questions, contact your Hartford agent. Form PA-7597-1

**For Residents of California: CALIFORNIA COMPLAINT NOTICE:** WHENEVER THE HARTFORD OR ITS AGENT HAS BEEN UNABLE TO RESOLVE A CONSUMER COMPLAINT AFFECTING THE POLICY OR CERTIFICATE, THE STATE AGENCY LISTED BELOW MAY BE CONTACTED TO ASSIST THE COMPLAINANT IN PURSUING A RESOLUTION OF THE COMPLAINT: CALIFORNIA DEPARTMENT OF INSURANCE, CONSUMER SERVICES DIVISION, 300 SOUTH SPRING STREET, LOS ANGELES, CA 90013 TOLL FREE TELEPHONE: (800) 927-4357 Form PA-8292-1

**For Residents of Florida: NOTICE:** The benefits of the policy providing your coverage are governed by the laws of a state other than Florida.

**For Residents of Indiana: IMPORTANT NOTICE:** We are here to serve you. As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If for any reason you wish to contact: The Hartford, please write to us at: The Hartford, Hartford Plaza, COGS-1-34, Hartford, CT, 06115, Attn: James E. Parker. The Indiana Department of Insurance please write to: Public Information/Market Conduct, Indiana Department of Insurance, 311 W. Washington St., Suite 300, Indianapolis, IN 46204-2787 Consumer Hotline: 1-800-622-4461 In the Indianapolis Area: 1-317-232-2395. Form PA-8104-2

**For Residents of North Carolina: THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY ISSUED OUT-OF-STATE. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.** Form PA-8362

**For Residents of Texas: IMPORTANT NOTICE -** You may call The Hartford's toll-free telephone number for information or to make a complaint at: 1-800-428-5711. You may also write to The Hartford at: P.O. Box 2999, Hartford, CT 06104-2999. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: 1-800-252-3439. You may write the Texas Department of Insurance at: P.O. Box 149104, Austin, TX 78714-9104 FAX # (512) 475-1771. **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance. This notice is for information only and does not become a part or condition of this document.

**AVISO IMPORTANTE:** Para obtener informacion o para someter una queja: Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al: 1-800-428-5711. Usted tambien puede escribir a The Hartford: P.O. Box 2999, Hartford, CT 06104-2999. Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al: 1-800-252-3439. Puede escribir al Departamento de Seguros de Texas: P.O. Box 149104, Austin, TX 78714-9104. FAX # (512) 475-1771. **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concierne a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI). Este aviso es solo para proposito de informacion y no se convierte en parte o condicion este documento. Form PA-8422

**For Residents of Wisconsin:** If you are a resident of the State of Wisconsin, the following notice applies: **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS. PROBLEMS WITH YOUR INSURANCE?** - If you are

having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem. Hartford Life Insurance Companies, Group Benefits Division Policyholder Services, P.O. Box 2999, Hartford, CT 06104-2999. Telephone: (860) 843-8623. You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to: Office of the Commissioner of Insurance Complaints Department, P.O. Box 7873, Madison, WI 53707-7873 1-800-236-8517 1-608-266-0103 or you can call 1-800-236-8517 outside of Madison, or 266-0103 in Madison, and request a complaint form. Form PA-8560-3

## ERISA INFORMATION

### THE FOLLOWING NOTICE CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

UNIVERSITY HOSPITALS HEALTH SYSTEM GROUP BENEFIT PLAN

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2. **Plan Number**

LIFE - 560

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3. **Employer/Plan Sponsor**

UNIVERSITY HOSPITALS HEALTH SYSTEM  
3605 Warrensville Center Road  
Shaker Heights, OH 44122-5203

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4. **Employer Identification Number**

34-0714775

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5. **Type of Plan**

Welfare Benefit Plan providing Short Term Disability, Long Term Disability, Life and Accidental Death, Dismemberment and Loss of Sight Benefits.

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6. **Plan Administrator**

UNIVERSITY HOSPITALS HEALTH SYSTEM  
3605 Warrensville Center Road  
Shaker Heights, OH 44122-5203

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7. **Agent for Service of Legal Process**

For the Plan

UNIVERSITY HOSPITALS HEALTH SYSTEM  
3605 Warrensville Center Road  
Shaker Heights, OH 44122-5203

For the Policy:

Hartford Life And Accident Insurance Company  
200 Hopmeadow St.  
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.
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9. **Type of Administration** -- The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
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10. The Plan and its records are kept on a Policy Year basis.
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11. **Labor Organizations**

As kept of file by the Employer.

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

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## STATEMENT OF ERISA RIGHTS

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

### 1. Receive Information About Your Plan and Benefits

- a) 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.
- b) 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.
- c) 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.

### 2. 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.

### 3. 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. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

### 4. 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 (formerly known as the Pension and Welfare Benefits 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.

## **CLAIM PROCEDURES**

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

### **Claim Procedures for Claims Requiring a Determination of Disability**

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Plan, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

#### Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

### **Claim Procedures for Claims Not Requiring a Determination of Disability**

#### Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

## Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

**The Plan Described in this Booklet  
is Insured by the**

**Hartford Life and Accident Insurance Company**  
Hartford, Connecticut

**Member of The Hartford Insurance Group**