

YOUR BENEFIT PLAN

**IRON WORKERS DISTRICT COUNCIL OF
WESTERN NEW YORK AND VICINITY**

Questions or Complaints about Your Coverage

In the event You have questions or complaints regarding any aspect of Your coverage, You should contact Your Employee Benefits Manager or You may write to us at:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call Us at: 1-800-523-2233

When calling, please give Us the following information:

- 1) the policy number; and
- 2) the name of the policyholder (employer or organization), as shown in Your Certificate of Insurance.

Or You may contact Our Sales Office:

Hartford Life Insurance Company
Group Sales Department
325 Essjay Road
Suite 402
Williamsville, NY 14221
TOLL FREE: 877-496-5665
FAX: 716-276-2160

If you have a complaint, and contacts between you and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require we provide you with additional contact information:

For residents of:	Write	Telephone
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904	1(800) 852-5494 1(501) 371-2640 (in the Little Rock area)
California	State of California Insurance Department Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013	1(800) 927-HELP
Idaho	Idaho Department of Insurance Consumer Affairs 700 W State Street, 3rd Floor PO Box 83720 Boise, ID 83720-0043	1-800-721-3272 or www.DOI.Idaho.gov
Illinois	Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767	Consumer Assistance: 1(866) 445-5364 Officer of Consumer Health Insurance: 1(877) 527-9431
Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1(800) 622-4461 1(317) 232-2395 (in the Indianapolis Area)
Virginia	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23209	1(804) 371-9741 (inside Virginia) 1(800) 552-7945 (outside Virginia)
Wisconsin	Office of the Commissioner of Insurance Complaints Department P.O. Box 7873	1(800) 236-8517 (outside of Madison) 1(608) 266-0103 (in Madison) to request a complaint form.

The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read This certificate carefully.

Florida

The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida.

**STATE OF DELAWARE
The Civil Union and Equality Act of 2011
Effective January 1, 2012**

In accordance with Delaware law, insurers are required to provide the following notice to applicants of insurance policies issued in Delaware.

The Civil Union and Equality Act of 2011 ("the Act") creates a legal relationship between two persons of the same sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Delaware to spouses in a legal marriage. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Delaware law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to Chapter 2 of Title 13 of the Delaware Code or the State of Delaware website at www.delaware.gov/CivilUnions.

Georgia

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

**STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011**

In accordance with Illinois law, insurers are required to provide the following notice to applicants of insurance policies issued in Illinois.

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Maine

The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change the designation and, policy reinstatement if the insured suffers from organic brain disease and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Massachusetts

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Montana

Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.

North Carolina

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

- 1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
- 2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

**IMPORTANT TERMINATION
INFORMATION**

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.

THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. 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.

Texas

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

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 78714-9410
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

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.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached 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:

1-800-523-2233

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 78714-9410
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente 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).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.



CERTIFICATE OF INSURANCE
HARTFORD LIFE INSURANCE COMPANY

200 Hopmeadow Street
Simsbury, Connecticut 06089
(A stock insurance company)

Policyholder: IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
Policy Number: GL-872745
Policy Effective Date: September 1, 2012
Policy Anniversary Date: September 1, 2013

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. This certificate replaces any other certificate We may have given to You earlier under The Policy. Nothing in The Policy invalidates or impairs any rights or benefits granted in the certificate or by New York law. The Policy and certificate are on file with Us at Our home office. The Policy and certificate may be inspected at the office of the Policyholder. The rights of any certificateholder, insured or beneficiary shall not be affected by any provision not contained in the certificate, riders, endorsements or amendments.

Signed for the Company

Donald C. Hunt, Secretary

David N. Levenson, President

READ YOUR CERTIFICATE CAREFULLY. CERTAIN WAR RISKS ARE NOT ASSUMED.
IN CASE OF ANY DOUBT WRITE YOUR COMPANY FOR FURTHER EXPLANATION.

A note on capitalization in this Certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of March 1, 2013.

Cost of Coverage:

Non-Contributory Coverage: Basic Life Insurance
Basic Accidental Death and Dismemberment

Eligible Class(es) For Coverage: All Active members of the Iron Workers District Council of Western New York & Vicinity Locals in good standing in the Wage Replacement Plan, including members assigned to all reciprocal and non-reciprocal locations, with a minimum of 200 hours in last plan year, working or available for work in the USA, Puerto Rico, Guam, Canada and any other locations where the participant is covered by the Plan..

Full-time Member:

Eligibility:

- 1) Participating member of the Iron Workers District Council of Western New York Locals with a balance of at least 200 work hours in last Wage Replacement Account plan year (July 1 - June 30).
- 2) Minimum balance of \$400 in your Wage Replacement Account as of your initial Wage Replacement Account eligibility at one of the bi-annual open enrollments, and a \$150 balance in your WRA for each 12 month period thereafter.
- 3) Actively at work or available for work.

Eligibility Waiting Period for Coverage:

The period prior to the Plan Anniversary Date or bi-annual open enrollment dates (September 1 and March 1) after which you become an Active member.

Life Insurance Benefit

Amount of Life Insurance

Basic Amount of Life Insurance

Maximum Amount

\$25,000

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You by any Amount of Life Insurance in force, paid or payable in accordance with the Conversion Right.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit and Principal Sum for You by 35% on the Policy Anniversary Date following the date You attain age 65 and 50% when You attain age 70. The reduction will apply to the Amount of Life Insurance and Principal Sum in force immediately prior to the first reduction made.

The reduced amount of coverage will be rounded to the next higher multiple of \$500, if not already a multiple of \$500. An appropriate adjustment in premium will be made.

Reductions also apply if:

- 1) You become covered under The Policy; or
- 2) Your coverage increases;

on or after the date You attain age 65.

ACCIDENTAL DEATH AND DISMEMBERMENT SCHEDULE OF INSURANCE

Accidental Death and Dismemberment Benefit

Basic Principal Sum

Maximum Amount
\$25,000

Additional Accidental Death and Dismemberment Benefits

Seat Belt Benefit Amount:

Percentage of Accidental Death and Dismemberment Principal Sum: 10%
Maximum Amount: \$10,000
Minimum Amount: \$1,000

Air Bag Benefit Amount:

Percentage of Accidental Death and Dismemberment Principal Sum: 5%
Maximum Amount: \$5,000

Repatriation Benefit

Percentage of Accidental Death and Dismemberment Principal Sum: 5%
Maximum Amount: \$5,000

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the latest of:

- 1) the Policy Effective Date;
- 2) the date You become a member of an Eligible Class; or
- 3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Enrollment: *How do I enroll for coverage?*

For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Coverage will start on the date You become eligible.

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

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*

If, on the date You are to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date the Policy terminates; or
- 2) the Policy Anniversary Date or Bi-Annual Open Enrollment date following the date you cease to be an eligible participant in the WRA of the Iron Workers District Council of Western New York Locals.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all Members the same way.

The amount of continued coverage will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium;
- 3) may be continued up to the maximum time shown in the provisions; and
- 4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

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

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage may be continued until the last day of the month following the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 12 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued until the last day of the month following the month in which the lay off commenced. If the lay off becomes permanent, this continuation will cease immediately.

Status Change: If You are:

- 1) employed by the Policyholder; and
- 2) no longer in an Eligible Class due to a reduction in the number of scheduled hours You work;

Your coverage may be continued until the last day of the third consecutive month after the month in which Your scheduled hours were reduced.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages may be continued:

- 1) for a period of 12 consecutive month(s) from the date You were last Actively at Work; or
- 2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive month(s).

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Labor Dispute: If You are not Actively at Work as the result of a labor dispute, all of Your coverages may be continued during such dispute until the last day of the month in which the coverage terminated. If the labor dispute ends, this continuation will cease immediately.

Waiver of Premium: *Does coverage continue if I am Disabled?*

Waiver of Premium is a provision which allows You to continue Your Life Insurance coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:

- 1) will be the amount in force on the date You cease to be an Active Member;
- 2) will be subject to any reductions provided by The Policy; and
- 3) will not increase.

Eligible Coverages: *What coverages are eligible under this provision?*

This provision applies only to Your Basic Life Insurance.

Disabled: *What does Disabled mean?*

Disabled means You are prevented by injury or sickness from doing any work for wage or profit for which You are, or could become, qualified by:

- 1) education;
- 2) training; or
- 3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 12 months or less.

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*

To qualify for Waiver of Premium You must:

- 1) be covered under The Policy;
- 2) be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive month(s), starting on the date You were last Actively at Work; and
- 3) provide such proof within one year of Your last day of work as an Active Member.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

When Premiums are Waived: *When will premiums be waived?*

If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 9 month(s) You are Disabled. We have the right to:

- 1) require Proof of Loss that You are Disabled; and
- 2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 9 month(s) that You are Disabled, the 9 month waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 9 month period. If You return to work for more than 5 days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium: *What if I die before I qualify for Waiver of Premium?*

If You die within one year of Your last day of work as an Active Member, but before You qualify for Waiver of Premium, We will pay the Amount of Life Insurance which is in force for You provided:

- 1) You were continuously Disabled;
- 2) the Disability lasted or would have lasted 9 months or more; and
- 3) premiums had been paid for coverage.

Waiver Ceases: *When will Waiver of Premium cease?*

We will waive premium payments and continue Your coverage, while You remain Disabled, until the date You attain Normal Retirement Age if Disabled prior to age 60.

What happens when Waiver of Premium ceases?

When the Waiver of Premium ceases:

- 1) if You return to work in an Eligible Class, as an Active Member, then You may again be eligible for coverage as long as premiums are paid when due; or
- 2) if You do not return to work in an Eligible Class, coverage will end and You may exercise the Conversion Right if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

Effect of Policy Termination: *What happens to the Waiver of Premium if The Policy terminates?*

If The Policy terminates before You qualify for Waiver of Premium:

- 1) You may exercise the Conversion Right, provided You do so within the time limits described in such provision; and
- 2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium, Your coverage under the terms of this provision will not be affected.

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*

If You die while covered under The Policy, We will pay Your Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Accelerated Benefit: *What is the benefit?*

In the event that You are diagnosed as Terminally Ill while You are:

- 1) covered under The Policy for an Amount of Life Insurance of at least \$10,000; and
- 2) under Normal Retirement Age;

We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of Your Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. There will be no effect on premium due after the Accelerated Benefit Amount is paid under this benefit.

You may request a minimum Accelerated Benefit amount of 25% of the Amount of Insurance or \$50,000 if less, and a maximum of \$500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your Amount of Life Insurance. This option may be exercised only once.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of \$100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from \$25,000 to \$80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only \$25,000 now, You cannot request the additional \$55,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

Any benefits received under this benefit may be taxable. You should consult a personal Tax Advisor for further information.

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
 - 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;
- You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*

We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You do not submit proof of Terminal Illness satisfactory to Us, or if You refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill?*

If You are diagnosed by a Physician as no longer Terminally Ill and:

- 1) return to an Eligible Class, coverage will remain in force, provided premium is paid;
- 2) do not return to an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
- 3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid. In addition, any amount paid as an Accelerated Benefit is not available for conversion. Please see the Conversion Right provisions.

Conversion Right: *If coverage under The Policy ends or is reduced, do I have a right to convert?*

If Life Insurance coverage or any portion of it under The Policy ends for any reason, except non payment of premium, You have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Such reasons for the Life Insurance coverage ending include, but are not limited to termination of employment, termination of The Policy or change in classes eligible for insurance. Conversion is not available for any Amount of Life Insurance for which You were not eligible and covered under The Policy.

This right to convert also applies if Your Amount of Life Insurance reduces:

- 1) due to a change in class of persons covered under The Policy;
- 2) due to an amendment to The Policy; or
- 3) in accordance with the Reduction in Amount of Coverage Due to Age provision stated in the Schedule.

The amount that may be converted is limited to the amount of group coverage in force prior to termination, less any amount of group coverage remaining in force under The Policy, subject to the provisions outlined below.

If coverage under The Policy ends because The Policy is terminated, the amount which may be converted is limited to the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 45 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, except non payment of premium, the full amount of coverage which ended may be converted.

If this conversion right applies due to a reduction in the Amount of Insurance, then the amount of the insurance that may be converted will equal the amount by which the benefit is reduced. However, if the Amount of Insurance is reduced in accordance with the Reduction in Amount of Coverage Due to Age provision stated in the Schedule, then the amount of insurance that may be converted will equal the amount which, when added to the amount in force after the reduction, equals 80% of the Amount of Insurance immediately prior to reduction.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage?*

You will be given notice of the conversion privilege within 15 days before or after the terminating event which results in the conversion option. If such notice is not given, You will have an additional period in which to exercise conversion rights. If notice is given more than 15 days but fewer than 90 days after the terminating event, this additional period will end 45 days following the date You are given notice of the right to convert. Written notice of conversion rights will be presented to You or mailed by the Employer or Us to the last known address.

If notice is not given within 90 days after the terminating event, the conversion election period will terminate at the end of 90 days.

To convert Your coverage You must:

- 1) complete a Notice of Conversion Right form; and
- 2) have Your Employer sign the form.

The Insurer must receive this within:

- 1) 31 days after Life Insurance terminates or during any required extension of the conversion election period as noted above; or
- 2) 15 days from the date Your Employer signs the form;

whichever is later.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

- 1) complete and return the request form in the proposal; and
- 2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You under the Conversion Right:

- 1) will be effective as of the date group coverage under The Policy ends and is not continued or if the conversion election period is extended as noted above, the date the Insurer received the completed Notice of Conversion Right form; and
- 2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*

The Conversion Policy will:

- 1) be issued on any one of the Life Insurance policy forms then customarily issued by the Insurer, except term insurance; or
- 2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as The Policy;

- 2) any benefit other than the Life Insurance Benefit.

At Your option, the Conversion Policy may be preceded by a one year term insurance policy subject to the same conditions and a premium payable in any mode customarily offered by the Insurer.

If Your insurance terminates due to Your total and permanent disability, You may elect any one of the Life Insurance policy forms, including term insurance, customarily issued by the Insurer, subject to the same conditions, at the end of the one year period. At Your option, the Conversion Policy may be preceded by a one year term insurance policy subject to the same conditions.

The Conversion right is available for any Amount of Life Insurance which was, or is being, continued:

- 1) in accordance with the Waiver of Premium provision; or
- 2) in accordance with the Continuation Provisions.

If Conversion is elected, then coverage continued as outlined above will terminate.

The Incontestability provision for the amount converted does not start anew.

Death within the Conversion Period: *What if I die before coverage is converted?*

We will pay Your Amount of Life Insurance You would have had the right to apply for under this provision if:

- 1) coverage under The Policy terminates; and
- 2) You die within 31 days of date coverage terminates or during any required extension of the conversion election period as noted above; and
- 3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Effect of Waiver of Premium on Conversion: *What happens to the Conversion Policy if Waiver of Premium is later approved?*

If You apply and are approved for Waiver of Premium after an individual Conversion Policy has been issued, any benefit payable at Your death under The Policy will be paid only if the individual Conversion Policy is surrendered. The Insurer will refund the premium paid for such Conversion Policy.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Accidental Death and Dismemberment Benefit: *When is the Accidental Death and Dismemberment Benefit payable?*

If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss after We receive Proof of Loss, in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:	Benefit:
Life.....	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes.....	Principal Sum
One Hand and One Foot.....	Principal Sum
Speech and Hearing in Both Ears.....	Principal Sum
Either Hand or Foot and Sight of One Eye.....	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia).....	Principal Sum
Movement of Both Lower Limbs (Paraplegia).....	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia).....	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia).....	One-Half of Principal Sum
Either Hand or Foot.....	One-Half of Principal Sum
Sight of One Eye.....	One-Half of Principal Sum
Speech or Hearing in Both Ears.....	One-Half of Principal Sum
Movement of One Limb (Uniplegia).....	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand.....	One-Quarter of Principal Sum

Loss means with regard to:

- 1) hands and feet, actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing, entire and irrecoverable loss thereof;
- 3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- 4) movement, complete and irreversible paralysis of such limbs.

Seat Belt and Air Bag Benefit: *When is the Seat Belt and Air Bag Benefit payable?*

If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt and Air Bag Benefit if the Injury occurred while You were:

- 1) a passenger riding in; or
- 2) the licensed operator of;

a properly registered Motor Vehicle and were wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

If a Seat Belt Benefit is payable, We will also pay an Air Bag Benefit if You were:

- 1) positioned in a seat equipped with a factory-installed Air Bag; and
- 2) properly strapped in the Seat Belt when the Air Bag inflated.

The Seat Belt Benefit is the lesser of:

- 1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

The Air Bag Benefit is the lesser of:

- 1) an amount resulting from multiplying Your amount of Principal Sum by the Air Bag Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Motor Vehicle or its proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications.

The Seat Belt and Air Bag Benefit will not be payable if You are operating the Motor Vehicle at the time of Injury while:

- 1) Intoxicated; or
- 2) taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

Intoxicated means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Repatriation Benefit: *When is the Repatriation Benefit payable?*

If You sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Repatriation Benefit, if the death occurs outside the territorial limits of the state or country of Your place of permanent residence.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Repatriation Benefit will pay the least of:

- 1) the actual expenses incurred for transportation of the body to the place of burial or cremation;
- 2) the amount resulting from multiplying Your amount of Principal Sum by the Repatriation Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Exclusions (*applicable to all benefits except the Life Insurance Benefit and the Accelerated Benefit*): *What losses are not covered under The Policy?*

The Policy does not cover any loss caused or contributed to by:

- 1) intentionally self-inflicted Injury;
- 2) suicide or attempted suicide;
- 3) war or act of war, whether declared or not;
- 4) Injury sustained during service in the armed forces (land, water, air) of any country or international authority;
- 5) Injury sustained while taking narcotics, unless as prescribed by or administered by a Physician;
- 6) Injury to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation; or
- 7) Injury sustained or contracted in consequence of You being Intoxicated.

Intoxicated means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or

3) the results of other means of testing other substances; that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after:

- 1) the date of death; or
- 2) the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

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

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*

Written Proof of Loss should be sent to Us within 365 days after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
- 2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*

Life Insurance Benefits and benefits for loss of life under the Accidental Death and Dismemberment Benefits will be paid in accordance with the life insurance Beneficiary Designation.

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

- 1) the executors or administrators of Your estate; or
- 2) all to Your surviving Spouse; or
- 3) if Your Spouse does not survive You, in equal shares to Your surviving children; or
- 4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to \$500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

- 1) \$200 at Your death; and
- 2) monthly installments of not more than \$200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent,

then We may pay up to \$1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Unless otherwise provided by law, the Life Insurance Benefit is not subject to the claim of, or legal process by, any creditor of Your beneficiary.

Beneficiary Designation: *How do I designate or change my 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.

If You designate more than one beneficiary and do not specify the amounts, percentage shares, or order of payment, benefits payable will be divided equally among all beneficiaries. The share of any beneficiary who has died before You will go equally to the surviving beneficiaries, unless Your beneficiary designation states otherwise.

Beneficiary 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.

If You have designated an irrevocable beneficiary, You will be able to change that beneficiary only after We have received a signed release from Your irrevocable beneficiary.

In no event may a beneficiary be changed by a Power of Attorney, to the extent permitted by applicable law.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the provisions upon which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

- 1) must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to the claim; and
- 3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can The Policy be contested?*

Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment benefit.

No material misrepresentation made by You relating to Your 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 Your lifetime. In order to be used, the statement must be in writing and signed by You, a copy of which is or has been furnished to You or Your Beneficiary.

This two year period also applies to any additional amounts of Life Insurance which You request and is subject to evidence of insurability from the date such additional coverage becomes effective.

Assignment: *Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, 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 right to convert; and
- 3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is received by Us.

You may only change an absolute assignment made by You with written consent of the absolute beneficiary(s), and a copy of the written consent must be on file with Us.

We and the Policyholder assume 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.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Assignments 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 assignment or change of assignment.

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date written Proof of Loss is furnished; or
- 2) more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Insurance Fraud: *How does the Company deal with fraud?*

Insurance fraud is a crime. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You and/or the Employer perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

This adjustment will not apply to material facts, other than age or sex, after such insurance policy has been in force for a period of 2 years.

DEFINITIONS

Active Member - Active member means a member in good standing with the Iron Workers District Council of Western New York Locals.

Actively at Work means at work or available for work with the Iron Workers District Council of Western New York Locals on a day that is one of your scheduled workdays, scheduled vacation days, paid time off, personal days or holidays.

Employer means the Policyholder.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not Related to You by blood or marriage.

Related means Your spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

Union means Iron Workers District Council of Western New York Locals.

We, Us or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.

ACCIDENTAL DEATH AND DISMEMBERMENT DEFINITIONS

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 that concern.

Injury means bodily injury resulting:

- 1) directly from an accident; and
- 2) independently of all other causes;

which occurs while You are covered under The Policy.

Loss resulting from:

- 1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
- 2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

Motor Vehicle means a self-propelled, four (4) or more wheeled:

- 1) private passenger: car, station wagon, van or sport utility vehicle;
- 2) motor home or camper; or
- 3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

AMENDATORY RIDER



HARTFORD LIFE INSURANCE COMPANY

200 Hopmeadow Street
Simsbury, Connecticut 06089
(A stock insurance company)

This rider is attached to a certificate given in connection with The Policy.

This rider becomes effective on the certificate effective date.

This rider is intended to amend Your certificate, as indicated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your certificate will affect Your coverage. In addition, any reference made herein to Dependent coverage will only apply if Dependent coverage is provided in Your certificate.

For California residents:

3) The following is added to the definition of **Spouse**:

Spouse will also include an individual who is in a registered domestic partnership with You in accordance with California law. References to Your marriage or divorce will include Your registered domestic partnership or dissolution of Your registered domestic partnership.

4) The following is added to the definition of **Dependent Child(ren)**:

Dependent Child(ren) will also include child(ren) of Your California registered domestic partner.

For Colorado residents, the **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

For Connecticut residents:

1) The definition of **Dependent Child(ren)** is amended to include relationships due to domestic partnership.

2) The following is added to the definition of **Spouse**:

Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for the purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

For Louisiana residents:

1) The age limit stated in the **Continuation for Dependent Child(ren) with Disabilities** provision is increased to 21, if less than 21.

2) The following provision is added to the **PERIOD OF COVERAGE** provisions:

Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage ended;
- 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
- 3) be subject to all the terms and provisions of The Policy.

For Maryland residents:

1) The definition of **Dependent Child(ren)** is amended to include relationships due to domestic partnership.

2) The following is added to the definition of **Spouse**:

Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for the purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

For Massachusetts residents, the definition of **Terminal Illness or Terminally Ill** in the Accelerated Benefit cannot exceed 24 months.

For Minnesota residents:

- 1) The term "granted military leave of absence" in the Military Leave of Absence portion of the **Continuation Provisions** section, is amended to "documented military leave of absence."
- 2) The following applies to You if there are more than 25 residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy: The provision titled "**Lay Off**" is deleted from the Continuation Provisions and is replaced by the following:
Lay Off: If You are voluntarily or involuntarily terminated or Laid Off, You may elect to continue Your coverage by making monthly premium payments to the Employer for the cost of continued coverage. You must elect this continued coverage within 60 days from:
 - 1) the date Your coverage would otherwise terminate; or
 - 2) the date You receive a written notice of Your right to continue coverage;whichever is later. The amount of premium charged may not exceed 102% of the premium paid, either by You or the Employer, for life insurance coverage for an Active Employee. The Employer will inform You of:
 - 1) Your right to continue coverage;
 - 2) the amount of monthly premium; and
 - 3) how, where and by when payment must be made.Upon request, the Employer will provide You Our written verification of the cost of coverage. Coverage will continue until the first to occur of:
 - 1) the date You are covered under another group policy; or
 - 2) the last day of the 18th month following the date of termination or layoff.At the end of such 18 month period, You may exercise the Conversion Right if You do so within the time limits described in such provision. However, in lieu of conversion coverage You may accept a policy providing reduced benefits at a reduced premium rate. Minnesota law requires that if Your coverage ends because the Employer fails:
 - 1) to notify You of Your right to continue coverage; or
 - 2) to pay the premium after timely receipt;the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered. Laid Off means that there is a reduction in the number of hours You work for the Employer so that You are no longer eligible for coverage. The term termination does not include discharge for gross misconduct but does include retirement.
- 3) the 9th paragraph of the **Accelerated Benefit** provision is deleted.
- 4) the 2nd, 3rd and 4th paragraphs of the **Conversion Right** provision are deleted.
- 5) The first sentence of the 5th paragraph of the **Claims to be Paid** provision is amended as follows:
If benefits are payable and are greater than \$15,000, then You or Your beneficiary may request that We pay benefits into a draft book account (checking account) which will be owned by:
 - 1) You, if living; or
 - 2) Your beneficiary, in the event of Your death.

For Missouri residents:

- 1) The time periods stated in the **Conditions for Qualification** and the **Benefit Payable before Approval of Waiver of Premium** provisions are changed to 180 days, if greater than 180 days.
- 2) The following language is added to the **When Premiums are Waived** provision:
If Waiver of Premium is approved, it will be retroactive to the date the disability began. Premiums will be waived retrospectively once You have completed the 180 day waiting period.
- 3) The **Suicide** provision is replaced by the following:
Suicide: *What benefit is payable if death is a result of suicide?*
If You or Your Dependent commit suicide, whether sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 1 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings. If You or Your Dependent die as a result of suicide, whether sane or insane, within 1 year of the Policy effective date, all premiums paid for coverage will be refunded.

This 1 year period includes the time group life insurance coverage was in force under the Prior Policy.

For Montana residents:

- 1) The time period stated in the **Conversion Right** provision is changed to 3 years, if greater than 3 years.
- 2) The following exclusions under the **Felonious Assault Benefit** provision are deleted:
 - 1) The Felonious Assault Benefit will not pay for a Loss that results from a Felonious Assault committed by a member of the injured person's family.
 - 2) The Felonious Assault Benefit will not pay for a Loss that results from a Felonious Assault committed by a member of the household in which the injured person lives.

For New Hampshire residents:

- 1) The **Waiver of Premium and Disability Extension** provision or the **Disability Extension** provision is deleted
- 2) The following is added to the end of the first paragraph of the **Conversion** provision:
The Notice of Conversion Right form will be mailed to You within 15 days after the Policy ceases. If notice is given more than 15 days after the Policy ceases, the time You have to convert will be extended for 15 days from the date notice was given.
- 3) The last sentence of the second paragraph of the **Conversion** provision is replaced by the following:
However, unless you did not have notice, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.
- 4) Item #3 in the second paragraph of the Sending Proof of Loss provision is deleted.
- 5) The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to \$250, if less than \$250.
- 6) The following is added to the Period of Coverage if Spouse Accidental Death and Dismemberment is included in the contract:
Spouse Continuation: *Can coverage be continued for a divorced Spouse?*
If You are legally separated or divorced from Your Spouse, coverage for Your former Spouse may continue under The Policy until the earliest of:
 - 1) the last day of the third year following the anniversary of a final divorce or legal separation;
 - 2) the date You remarry;
 - 3) the date Your former Spouse remarries;
 - 4) a date specified in the final divorce decree;
 - 5) the date Your former Spouse fails to pay any premiums that may be due; or
 - 6) the date You die.

For North Dakota residents, the **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

For Oregon residents:

- 1) The following is added to the definition of **Spouse**:
Spouse will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available.
- 2) The definition of **Dependent Child(ren)** is amended to include children related to You by domestic partnership.
- 3) The following is added to the **Continuation Provisions** for Employers with 10 or more employees:
Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
 - 1) elected to have Your coverage continued; and
 - 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

For South Carolina residents:

- 1) The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to \$2,000, if greater than \$2,000.
- 2) The lead-in of the second half of the first paragraph of the **Continuity from a Prior Policy for Disability Extension** provision is amended to read "Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum:"
- 3) Item 3) "3) The Policy terminates or Your Employer ceases to be a Participating Employer;" of the second paragraph of the **Waiver Ceases** provision is deleted.
- 4) Items 1) and 2) of the first paragraph of the **Disability Extension Ceases** provision are deleted.
- 5) Item 3) "3) The Policy terminates or Your Employer ceases to be a Participating Employer;" of the **Disability Extension Ceases** provision is deleted.

- 6) The following paragraph is added between the first and second paragraphs of the **Disability Extension Ceases** provision:
 In the event of Policy termination or Your Employer ceases to be a Participating Employer Your coverage will continue for a period of 12 months from the date of Policy termination as long as premiums are paid when due. This period will be subject to the terms and conditions of this provision.
- 7) The following paragraph is added between the second and third paragraphs of the **Disability Extension Ceases** provision:
 In the event of Policy termination or Your Employer ceases to be a Participating Employer Dependent coverage will continue for a period of 12 months from the date of Policy termination as long as premiums are paid when due. This period will be subject to the terms and conditions of this provision.
- 8) The following paragraph is added at the end of the **Disability Extension Ceases** provision:
 When the 12 month extension period ceases after The Policy terminates, coverage will end and You may be eligible to exercise the Conversion Right for You and Your Dependents if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right. Portability will not be available.
- 9) Item 1) of the last paragraph of the **Effect of Policy Termination** provision is amended to read:
 "Your Dependent coverage will continue for a period of 12 months from the date of Policy Termination and will be subject to the terms and conditions of this provision; and"

For South Dakota residents:

The definition of **Physician** is deleted and replaced by the following:

Physician means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Your Spouse or Related to You or Your Spouse by blood or marriage, unless such physician is the only one in the area and is acting within the scope of their normal employment.

For Utah residents:

- 1) The time period stated in the **Claim Forms** provision is changed to 15 days.
- 2) Item 3 of the second paragraph of the **Sending Proof of Loss** provision is deleted.
- 3) The time period stated in the **Claim Payment** provision is changed to 45 days if more than 45 days.
- 4) The provision titled **Policy Interpretation** is replaced in its entirety as follows:

Policy Interpretation: *Who interprets the terms and conditions of the Policy?*

Benefits under this plan will be paid only if We decide in Our discretion that You or Your Dependents are entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms and conditions of the benefit plan. Determinations made by Us pursuant to this reservation of discretion do not prohibit or prevent You or Your Dependents from seeking judicial review in federal court of Our determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when You or Your Dependents seek judicial review of Our determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the benefit plan.

We are an insurance company that provides insurance to this benefit plan and the federal court will determine the level of discretion that it will accord to Our determinations.

- 5) The phrase "In the absence of fraud" are deleted from the **Incontestability** provision.
- 6) The following "Sickness or Injury" continuation, will apply if the continuation included is for less than 6 months, or is added to the **Continuation Provisions** if not already included:
Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:
 - 1) for a period of 6 consecutive months from the date You were last Actively at Work; or
 - 2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 6 consecutive months.

For Vermont residents:

The following Endorsement applies:

Purpose: This endorsement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

- 1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
- 2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
- 3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
- 4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.
- 5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

Cautionary Disclosure: THIS RIDER IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE RIDER. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS RIDER. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

For Virginia residents, any and all references to Domestic Partners are hereby deleted.

For Washington residents:

- 1) The provision titled **Disputed Diagnosis** is added as follows:

Disputed Diagnosis: *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*

If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

- 2) The **Labor Dispute** continuation provision is replaced with the following:

Labor Dispute: If You are not Actively at Work as the result of a labor dispute, all of Your coverages (including Dependent Life coverage) may be continued during such dispute for a period not exceeding 6 months. If the labor dispute ends, this continuation will cease immediately.

- 3) The provision titled **Policy Interpretation** is deleted in its entirety.

- 4) The following provision is added to the **General Provisions** section of Your certificate:

Eligibility Determination: *How will We determine Your or Your Dependent's eligibility for benefits?*

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

- 1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably

require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;

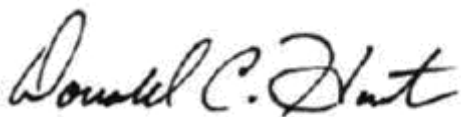
- 2) consider and interpret The Policy and all information obtained by Us and submitted by You or Your beneficiaries that relates to Your or Your beneficiaries' claim for benefits and make Our determination of Your or Your Dependent's eligibility for benefits based on that information and in accordance with The Policy and applicable law;
- 3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
- 4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

- 5) The definition of **Dependent Child(ren)** is amended to include relationships due to domestic partnership.
- 6) The following is added to the definition of **Spouse**:
Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for the purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.
- 7) The provision titled **Suicide** is deleted in it's entirety and any suicide restrictions appearing in **Continuity from a Prior Policy, Reinstatement** and/or **Occupational Death Benefit** will not apply.

In all other respects the certificate remains the same.

Signed for Hartford Life Insurance Company.



Donald C. Hunt, Secretary



David N. Levenson, President

**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 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.

1. Plan Name

Group Basic Term Life, Basic Accidental Death and Dismemberment Plan for Employees of IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY.

2. Plan Number

LIFE - 501

ADD - 501

3. Employer/Plan Sponsor

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
3445 Winton Place, Suite 110
Rochester, NY 14623

4. Employer Identification Number

16-0776208

5. Type of Plan

Welfare Benefit Plan providing Group Basic Term Life, Basic Accidental Death and Dismemberment.

6. Plan Administrator

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
3445 Winton Place, Suite 110
Rochester, NY 14623

7. Agent for Service of Legal Process

For the Plan
IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
3445 Winton Place, Suite 110
Rochester, NY 14623

For the Policy:

Hartford Life 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.

8. **Sources of Contributions** The Employer pays the premium for the insurance, but may allocate part of the cost to the member, or the member may pay the entire premium. The Employer determines the portion of the cost to be paid by the member. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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.

10. The Plan and its records are kept on a Policy Year basis.

11. Labor Organizations

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY
3445 Winton Place, Suite 110
Rochester, NY 14623

12. 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.

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 Insurance Company
Simsbury, Connecticut
Member of The Hartford Insurance Group**