

## **NOTICE TO INSUREDS**

READ THIS NOTICE CAREFULLY BEFORE ACCESSING THE FOLLOWING INFORMATION. MetLife is providing this Electronic Document describing the insurance benefits provided for in your certificate of insurance as a convenience. Trinity Health Corporation maintains the group insurance policy, including a copy of the certificate of insurance that is available for you to review and copy if necessary. If there is any conflict between the information in this Electronic Document and the group insurance policy and certificate, the policy and certificate shall control in all aspects.

**YOUR EMPLOYEE  
BENEFIT PLAN**

**TRINITY HEALTH CORPORATION**

**Trinity Home Health Services  
Homecare  
Hospice  
Corporate**

**Effective January 1, 2006**

**Basic Life Benefits  
Optional Life Benefits  
Dependent Life Benefits  
Accidental Death or Dismemberment Benefits**

Trinity Health Corporation  
27870 Cabot Drive  
Novi, Michigan 48337-2920

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Trinity Health Corporation by Metropolitan Life Insurance Company.

Trinity Health Corporation



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

C. Robert Henrickson  
President and Chief Operating Officer

Employer: **Trinity Health Corporation**

Group Policy No.: **105068-1-G**

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

**For Maryland residents: 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.**

Accelerated Benefits may be taxable. If so, you or your Beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this Benefit.

**Texas Residents: Please Read the Notice Pages for Texas Residents Carefully**

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

**For Texas Residents:**

**IMPORTANT NOTICE**

To obtain information or make a complaint:

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

1-800-638-5433

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  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # 512 - 475-1771

**PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:** This notice is for information only and does not become a part or condition of the attached document.

**Para Residentes de Texas:**

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # 512 - 475-1771

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU CERTIFICADO:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

For Texas Residents:

#### IMPORTANT NOTICES

DEATH BENEFITS WILL BE REDUCED IF AN ACCELERATION-OF-LIFE-INSURANCE BENEFIT IS PAID.

**DISCLOSURE:** The acceleration-of-life-insurance benefits offered under this certificate are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the acceleration-of-life-insurance benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under the federal law.

**DISCLOSURE:** Receipt of acceleration-of-life-insurance benefits may affect your, your spouse's or your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect your, your spouse and your family's eligibility for public assistance.

**Arkansas residents please be advised of the following:**

**IMPORTANT NOTICE**

**IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:**

**1-800-638-5433**

**IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:**

**ARKANSAS INSURANCE DEPARTMENT  
CONSUMER SERVICES DIVISION  
1200 WEST THIRD  
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

**IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT,  
CONTACT METLIFE AT:**

**METROPOLITAN LIFE INSURANCE COMPANY  
200 PARK AVENUE  
NEW YORK, NY 10166  
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT  
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL  
THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY  
FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

**Georgia residents please be advised of the following:**

**IMPORTANT NOTICE**

**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 violence.**

**IMPORTANT NOTICE**

**NOTICE FOR RESIDENTS OF MONTANA**

**If a claim on your life or your Dependent's life becomes payable under this certificate, settlement of the claim shall be made within 60 days of the date that we receive proof of death that is satisfactory to us. The settlement shall include interest from the 30th day after we receive such proof until settlement. Such interest shall be paid at the rate required by law in Montana.**

**Utah residents please be advised of the following:**

## **NOTICE TO POLICYHOLDERS**

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

### **PEOPLE ENTITLED TO COVERAGE**

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

### **POLICIES COVERED**

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

### **EXCLUSIONS AND LIMITATIONS**

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

## LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

## DISCLAIMER

### ***PLEASE READ CAREFULLY:***

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance  
Guaranty Association  
955 E. Pioneer Rd.  
Draper, Utah 84114

Utah Insurance Department  
State Office Building, Room 3110  
Salt Lake City, Utah 84114

**Virginia residents please be advised of the following:**

**IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company  
200 Park Avenue  
New York, New York 10166  
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23209

1-800-552-7945 - In-state toll-free  
1-804-786-3741 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

**Wisconsin residents please be advised of the following:**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company  
Corporate Consumer Relations Department  
200 Park Avenue  
New York, NY 10166  
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517 outside of Madison or 266-0103 in Madison.

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**SCHEDULE OF BENEFITS**  
**(Also see SCHEDULE SUPPLEMENT)**

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The following Benefits are provided subject to the provisions below.

<u><b>BENEFITS (EMPLOYEE ONLY)</b></u>	<u><b>AMOUNT</b></u>
<b>BASIC LIFE</b>	
<b>Full-Time Employees</b> .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 2
Maximum Benefit .....	\$1,000,000
<b>Part-Time Employees</b> .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 1
Maximum Benefit .....	\$1,000,000
<b>Corporate (Full-Time and Part-Time) Employees</b>	
Option 1 .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 2
Option 2 .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 1
Maximum Benefit .....	\$1,000,000
<b>OPTIONAL LIFE</b>	
All Employees who elect:	
Option 1 .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 1
Option 2 .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 2
Option 3 .....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 3

Option 4.....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 4
Option 5.....	An amount equal to your Basic Annual Earnings, as determined by your Employer, rounded to the next higher \$1,000, if not a multiple thereof, times 5
Maximum Basic and Optional Life Benefit Combined ..	\$1,000,000

Only your Life Benefits will be reduced if Accelerated Benefits are paid. Any amount of Accidental Death or Dismemberment Benefits will be based on the amount of your earnings used to determine the amount of your Life Benefits in effect at the date payment of the Accelerated Benefit is made subject to any change in your earnings as described in the Increase and Decrease provisions in this SCHEDULE OF BENEFITS.

See pages hereof entitled ACCELERATED LIFE BENEFITS OR DEATH BENEFITS FOR TOTAL AND PERMANENT DISABILITY (On Your Own Account).

You may request payment of an Accelerated Benefit from your Basic or Optional Life Benefits or from both. If you elect payment from both your Basic and Optional Life Benefits, the Accelerated Benefits payment will be determined in accordance with the pages hereof entitled ACCELERATED LIFE BENEFITS OR DEATH BENEFITS FOR TOTAL AND PERMANENT DISABILITY (On Your Own Account), but not more than \$250,000 will be payable for Basic Life and not more than \$250,000 for Optional Life.

If you elect group optional life insurance coverage a will preparation service (the "Service") will be made available to you, through a MetLife affiliate (the "Affiliate"), while your group optional life insurance coverage is in effect. This Service will be made available at no cost to you. It enables you to have a will prepared for you and your spouse free of charge by attorneys designated by the Affiliate. If you have a will prepared by an attorney not designated by the Affiliate, you must pay for the attorney's services directly. Upon proof of such payment, you will be reimbursed for the attorney's services in an amount equal to the lesser of the amount you paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate.

**ACCIDENTAL DEATH OR DISMEMBERMENT**..... An amount equal to your Basic Life Benefits

**BENEFITS (DEPENDENTS ONLY)**

**NOTE:**

IF YOU AND YOUR SPOUSE ARE BOTH EMPLOYEES OF THE EMPLOYER AND ARE COVERED FOR PERSONAL OPTIONAL LIFE BENEFITS UNDER THIS PLAN, YOU MAY NOT COVER YOUR SPOUSE AS A DEPENDENT FOR LIFE BENEFITS (ON ACCOUNT OF DEPENDENTS) UNDER THIS PLAN.

<b>DEPENDENT LIFE</b>	<b><u>AMOUNT</u></b>
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**Spouse**

Spouse.....	Multiples of \$10,000 up to a Maximum Benefit of \$100,000
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**Child**

Child:

Less than 6 months..... \$2,000

Spouse..... Multiples of \$2,000 up to a Maximum Benefit of \$20,000

**Corporate Employees**

**Spouse**

Option 1 .....\$ 10,000

Option 2 .....\$ 20,000

Option 3 .....\$ 50,000

Option 4 .....\$100,000

**Child**

Less than 6 months.....\$ 2,000

(6 months and over):

Option 1 .....\$ 2,000

Option 2 .....\$ 5,000

Option 3 .....\$10,000

Option 4 .....\$20,000

See pages hereof entitled ACCELERATED LIFE BENEFITS FOR TOTAL AND PERMANENT DISABILITY (ON ACCOUNT OF YOUR DEPENDENT SPOUSE).

**INCREASES AND DECREASES IN AMOUNTS OF  
BASIC AND OPTIONAL LIFE BENEFITS  
AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

Your earnings on the date you become covered under This Plan will determine your benefits on that date. Any increase or decrease in your benefits will take place on the date of change in your earnings provided you are Actively at Work on that date. If you are not Actively at Work on the date of change in your earnings, the change in your benefits will take place when you return to Active Work.

**PROVISIONS APPLICABLE TO  
BASIC LIFE BENEFITS GREATER THAN \$500,000**

In order to be covered for an amount of Basic Life Benefits greater than \$500,000, evidence of your good health must be given to us. The evidence of good health is to be given at your expense\*.

If the evidence of good health is accepted by us as satisfactory, such amount of Basic Life Benefits will be effective on the later of:

- a. the date your Basic Life Benefits would otherwise be effective; or
- b. the date the evidence of good health is accepted by us;

provided you are Actively at Work on that date. If you are not Actively at Work on that date, such amount of Basic Life Benefits will become effective on the date of your return to Active Work.

If the evidence of good health is not accepted by us as satisfactory, the amount of your Basic Life Benefits will be limited to \$500,000.

\*If during an annual enrollment period, we ask you to provide us with evidence of your good health, you will not be responsible for the cost of providing such evidence of good health.

**PROVISIONS APPLICABLE TO OPTIONAL LIFE BENEFITS  
IN AN AMOUNT GREATER THAN \$500,000**

1. You must, at your expense\*, give us evidence of your good health in order to:
  - a. become covered under This Plan for an amount of Optional Life Benefits greater than \$500,000; or
  - b. receive, due to an increase in your earnings, an increase in the amount of Optional Life Benefits of \$100,000 or more if you are already covered for an amount of Optional Life Benefits greater than \$500,000.
2. If we accept the evidence of your good health as satisfactory, such amount of Optional Life Benefits or such increase in the amount of Optional Life Benefits will become effective on the later of:
  - a. the date we accept the evidence of your good health; or
  - b. the effective date of your Personal Benefits;

provided you have satisfied the Work Requirements. If you have not satisfied the Work Requirements, such amount of Optional Life Benefits or such increase in the amount of Optional Life Benefits will become effective on the first day after you satisfy the Work Requirements.

3. If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the amount of your Optional Life Benefits will not be more than:
  - a. the amount of Optional Life Benefits for which you were covered immediately prior to the date on which any such increase would have become effective; or
  - b. \$500,000

as defined by the administrative practices of your Ministry Organization.

\*If, during an annual enrollment period, we ask you to provide us with evidence of your good health, you will not be responsible for the cost of providing such evidence of good health.

## IF YOU CHANGE YOUR OPTIONAL LIFE BENEFIT COVERAGE

- A. Increase in Coverage:** If you are covered for Optional Life Benefits and make written application to increase coverage, you must give us evidence of good health, at your own expense\*. If we accept your evidence of good health as satisfactory, the increase in Optional Life Benefits will take effect as of the date we accept it if you have satisfied the Work Requirements. If you are required to submit evidence of good health and do not; or if you submit evidence of good health and we do not accept it; or if you fail to satisfy the Work Requirements at the time you submit your application or the time we accept your evidence of good health, whichever is later; the amount of your Optional Life Benefits will not change.
- B. Decrease in Coverage:** If you are covered for Optional Life Benefits and make written application to decrease your coverage under one of the options of the Plan, that decrease will take effect as of the date of your application.

\*If, during an annual enrollment period, we ask you to provide us with evidence of your good health, you will not be responsible for the cost of providing such evidence of good health.

## PROVISIONS APPLICABLE TO DEPENDENT LIFE BENEFITS ON YOUR DEPENDENT SPOUSE IN EXCESS OF \$20,000

1. You must, at your own expense\*, give us evidence of the good health of your Dependent spouse in order for your Dependent spouse to become covered under This Plan for an amount of Dependent Life Benefits greater than \$20,000.
2. Such amount of Dependent Life Benefits will become effective for your Dependent spouse on the later of:
  - a. the date the evidence of good health of your Dependent spouse is accepted by us as satisfactory; or
  - b. the effective date of your Personal Benefits;provided you are Actively at Work on that date. If you are not Actively at Work on that date, such amount of Dependent Life Benefits will become effective on the date of your return to Active Work.
3. If you do not give us evidence of the good health of your Dependent spouse, or if such evidence of good health is not accepted by us as satisfactory, the amount of Dependent Life Benefits will not be more than the amount of Dependent Life Benefits which was in effect on your Dependent Spouse immediately prior to the date on which any such increase would have become effective.

\*If, during an annual enrollment period, we ask you to provide us with evidence of your good health, you will not be responsible for the cost of providing such evidence of good health.

## AMOUNT OF CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY

### Applicable to Basic Life Benefits Only

The amount of your Death Benefits will be determined by the table below. The percentage for your age on the date of your death is to be applied to the amount of your Life Benefits on the date your Life Benefits ended.

<u>If You Die</u>	<u>Percentage</u>
Before age 65	100%
On or after age 65	0%

Your Death Benefits will be reduced if Accelerated Benefits are paid.

## WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

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## SCHEDULE SUPPLEMENT

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### A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

### B. Assignment

The benefits with respect to the Life Benefits (On Your Own Account) and the Accidental Death or Dismemberment Benefits under This Plan may be assigned as a gift. The benefits with respect to the Life Benefits (On Your Own Account) are also assignable by means of a viatical assignment. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.
2. The privilege of obtaining an individual policy of life insurance.
3. The right to change the Beneficiary.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.
2. The assignment is accepted, in writing, by us and by the Employer.
3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

**C. Additional Provisions**

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
  - a. to accept or to waive the required notice or proof of a claim; nor
  - b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

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**DEFINITIONS OF CERTAIN TERMS USED HEREIN**

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**"Actively at Work" or "Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;
2. provided you are not disabled.

**"Basic Annual Earnings"** means an Employee's annual wage or salary as defined and reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, or overtime pay.

**"Covered Person"** means an Employee or a Dependent on whose account benefits are in effect under This Plan.

**"Dependent"** means your spouse or your unmarried child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;
2. a person who is covered under This Plan as an Employee;
3. a person who lives outside the United States or Canada;
4. an unborn or stillborn child; or
5. a child who is 24 years of age or older.

NOTE: Coverage will continue until the end of the calendar year in which such child no longer qualifies as a Dependent.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

- a. that child is and remains unable to work in self-sustaining employment because of:

- i. physical handicap; or
- ii. mental retardation; and
- b. that child is and remains chiefly dependent upon you for support; and
- c. that child is and remains a Dependent, as defined, except for the age limit; and
- d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and
- e. you make any payment which is required by the Employer.

Child includes:

- a. a child who is supported solely by you; and
- b. a child who is legally adopted; and
- c. a stepchild who lives in your home; and
- d. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree).

No person may be covered as a Dependent of more than one Employee.

**"Dependent Benefits"** mean the benefits which are provided on account of a Dependent under This Plan.

**"Doctor"** means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. the service performed by the practitioner is within the scope of his or her license.

**"Employee"** means a person who is actively employed and paid for services by Trinity Home Health Services-Homecare; Trinity Home Health Services-Hospice; or Trinity Home Health Services-Corporate on a full-time or part-time basis and meets the employment hours requirement defined by their Ministry Organization.

Employee does not include any person who is employed and paid for services by the Employer on a temporary or seasonal basis, or is a non-benefit eligible person, as determined by the Employer.

**"Enrollment Form"** means the form used by you to request:

1. Personal Benefits; and
2. Dependent Benefits;

which contains certain medical questions which the applicant must complete.

**"Hospitalized"** means that you or your Dependent has received:

1. inpatient care in a hospital; or

2. care in:
  - a. a hospice facility; or
  - b. an intermediate facility; or
  - c. a long term care facility; or
3. chemotherapy; or
4. radiation therapy; or
5. dialysis treatment.

**"Normal Activities"** means that your Dependent:

1. is not confined in a hospital; or
2. is not confined at home under the care of a Doctor for a sickness or injury; or
3. is not receiving and is not entitled to receive any disability income from any source due to any sickness or injury.

**"Personal Benefits"** mean the benefits which are provided on account of an Employee under This Plan.

**"Qualifying Events"** means a change in your family, employment or group coverage status which would affect your Benefits under This Plan due to one or more of the following:

1. marriage;
2. birth, adoption or placement for adoption of a dependent child;
3. divorce, legal separation or annulment;
4. death of a dependent;
5. your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage;
6. a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage.

**"This Plan"** means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

**"Total Disability" or "Totally Disabled"** means that because of a sickness or an injury:

1. you can not do your job; and
2. you can not do any other job for which you are fit by your education, your training or your experience.

**"We", "us" and "our"** mean Metropolitan.

**"Work Requirements"** means that you have:

1. worked as an Employee at least 20 hours during the last 7 consecutive calendar days; and

2. worked at either your usual place of business or away from your usual place of business at your Employer's convenience.

"You" and "your" mean the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

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## ELIGIBILITY FOR BENEFITS

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### Personal Benefits Eligibility Date

Your Personal Benefits Eligibility Date is the later of:

1. January 1, 2006; or
2. the first day of the calendar month after the date you complete 30 days of continuous service as an Employee of the Employer.

### Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date or the date you first acquire a Dependent.

Form G.23000-C

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## EFFECTIVE DATES OF PERSONAL BENEFITS

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This Plan provides one or more Non-Contributory Benefit(s) and one or more Contributory Benefit(s). The applicable provisions set forth below will be applied separately to each benefit.

### APPLICABLE TO NON-CONTRIBUTORY BENEFITS (Basic Life and Accidental Death or Dismemberment Benefits)

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date provided you are then Actively at Work as an Employee. If you are not then Actively at Work as an Employee, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

### APPLICABLE TO CONTRIBUTORY BENEFITS (Optional Life Benefits)

#### A. Making a Request for Benefits

1. Your Employer has established a flexible benefits plan. Under such a plan, you can choose the amount and types of benefits subject to the rules of the plan. Such rules include time frames during which you may make a request to be covered or to change your benefits under This Plan as set forth below. Such rules also establish a time frame for when changes in the amount of your benefits are made as a result of a change in your class or earnings. Your Employer can provide you with more information regarding the flexible benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a request to the Employer on the flexible benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. when you are first eligible for Personal Benefits; and
- b. when you have a Qualifying Event and want to make a change in your coverage for Personal Benefits to be more consistent with your new family status; and
- c. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the thirty-one day period following your Personal Benefits Eligibility Date; or
- c. within thirty-one days of a Qualifying Event.

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
  - b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.
2. If you make a request to be covered for Personal Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Work Requirements.
  3. If you make a request to be covered for Personal Benefits or a request for change(s) in Personal Benefits within thirty-one days of a Qualifying Event, your Personal Benefits or the change(s) in Personal Benefits will become effective on the date of the Qualifying Event, subject to the Work Requirements, and provided that the change in coverage is consistent with your new family status.
  4. If you are not insured for Personal Benefits and make a request to be insured for Personal Benefits, during an annual enrollment period but more than 31 days after your Personal Benefits Eligibility Date, evidence of your good health must be given to us.
  5. If you make a request to change your Personal Optional Life Benefits during an annual enrollment period, your Personal Optional Life Benefits will become effective on the first day of the calendar year following the annual enrollment period, subject to the Active Work Requirement.
  6. If you make a request, during an annual enrollment period, to increase your Optional Life Benefits to an option of the Plan providing the next higher level of benefits, evidence of your good health is not required. The increased amount of Optional Life Benefits will become effective on the first day of the calendar year following the annual enrollment period, subject to the Work Requirements.

However, if the increased amount of Optional Life Benefits brings the total amount of your Optional Life Benefits to an amount greater than \$500,000, then you must give us evidence of your good health, in accordance with the provisions of the form entitled SCHEDULE OF BENEFITS.

7. If you make a request, during an annual enrollment period, to increase your Optional Life Benefits to an option of the Plan providing more than the next higher level of benefits, you must give us evidence of your good health.

8. If you make a request, during an annual enrollment period, to decrease your Optional Life Benefits to an option of the Plan providing a lower level of benefits, the decreased amount of Optional Life Benefits will become effective on the first day of the calendar year following the annual enrollment period.

**B. Evidence of Good Health**

The evidence of good health is to be given at your expense\*. Your Personal Benefits will become effective on the first day of the month following the date such evidence of good health is accepted by us as satisfactory, subject to the Work Requirements.

If the evidence of your good health is not accepted by us as satisfactory, you will not be covered for Personal Benefits.

\*If, during an annual enrollment period, we ask you to provide us with evidence of good health, you will not be responsible for the cost of providing such evidence of good health.

**C. Active Work Requirement**

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

**D. Reinstatement of Benefits**

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

**E. Work Requirements**

For Optional Life Benefits, you must satisfy the Work Requirements in order for your Personal Benefits to become effective. If you have not satisfied the Work Requirements on the date when your Personal Benefits would otherwise become effective, these benefits will become effective on the first day after you satisfy the Work Requirements.

Form G.23000-D1

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**EFFECTIVE DATES OF DEPENDENT BENEFITS**

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**A. Making a Request for Benefits**

1. In order to become insured for Dependent Benefits under This Plan, you must make a request to the Employer on the flexible benefits enrollment form furnished by the Employer.

Requests to be insured for Dependent Benefits may only be made:

- a. during the thirty-one day period following your Dependent Benefits Eligibility Date; and
- b. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; and

- c. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

Requests for changes in your Dependent Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
  - b. within thirty-one days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.
2. If you make a request to be insured for Dependent Benefits within thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, subject to the Additional Requirements, and, on the latest of:
- a. your Dependent Benefits Eligibility Date; or
  - b. the effective date of your Personal Benefits; or
  - c. the date the information on the enrollment form related to such Dependent is accepted by us as satisfactory.
3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within thirty-one days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective on the latest of:
- a. the date of the Qualifying Event; or
  - b. the effective date of your Personal Benefits; or
  - c. the first day of the month following the date of your request;

subject to the Additional Requirements, and provided that the change in coverage is consistent with your new family status.

4. If you are not insured for Dependent Benefits and make a request to be insured for Dependent Benefits, during an annual enrollment period but more than 31 days after your Dependent Benefits Eligibility Date, evidence of the good health of each such Dependent must be given to us.
5. If you make a request, during an annual enrollment period, to increase your Dependent Life Benefits to an option of the Plan providing the next higher level of benefits, evidence of your Dependent's good health is not required. The increased amount of Dependent Life Benefits will become effective on the first day of the calendar year following the annual enrollment period.

However, if the increased amount of Dependent Life Benefits is more than \$20,000, then you must give us evidence of the good health\* of each of your Dependents, in accordance with the provisions of the form entitled SCHEDULE OF BENEFITS.

6. If you make a request, during an annual enrollment period, to increase your Dependent Life Benefits to an option of the Plan providing more than the next higher level of benefits, you must give us evidence of the good health of each of your Dependents.
7. If you make a request, during an annual enrollment period, to decrease your Dependent Life Benefits to an option of the Plan providing a lower level of benefits, the decreased amount of Dependent Life Benefits will become effective on the first day of the calendar year following the annual enrollment period.

## **B. Additional Requirements**

If, on the date you would have become insured under This Plan for Life Benefits (On Account of Dependents), a Dependent:

1. has been Hospitalized in the last three months prior to the date you make a request for Dependent Benefits under This Plan;
2. is then Hospitalized; or
3. is not then able to perform Normal Activities;

then evidence of the good health of each such Dependent must be given to us.

## **C. Evidence of Good Health**

The evidence of good health is to be given at your expense\*. Your Dependent Benefits will become effective for each such Dependent for whom evidence of good health must be given to us on the later of:

1. the date the evidence of the good health of such Dependent is accepted by us as satisfactory; or
2. the effective date of your Personal Benefits.

If the evidence of the good health of any person is not accepted by us as satisfactory, such person:

1. will be deemed not to be a Dependent for the purpose of Dependent Benefits; and
2. will not be covered for Dependent Benefits.

\*If, during an annual enrollment period, we ask you to provide us with evidence of good health, you will not be responsible for the cost of providing such evidence of good health.

## **D. Reinstatement of Benefits**

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

## **E. New Dependents**

If you are insured for Dependent Benefits and acquire a new Dependent, such event may be considered, subject to the provisions of the flexible benefits plan, as a Qualifying Event. The effective date of Dependent Benefits with respect to such person who becomes your Dependent would be determined in accordance with the foregoing provisions.

Form G.23000-D2

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**LIFE BENEFITS**  
**(On Your Own Account)**

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**A. Coverage**

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

**B. Optional Types of Payment**

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

**C. Suicide Provision (Applicable to Optional Life Benefits)**

Optional Life Benefits will not be paid to the Beneficiary if you commit suicide, while sane or insane, within 2 years from the effective date of your Optional Life Benefits. Instead we will pay the Beneficiary an amount equal to any contributions paid, without interest.

If you commit suicide, while sane or insane, more than 2 years after the effective date of your Optional Life Benefits, but within 2 years from the effective date of any increase in the amount of your Optional Life Benefits, such increased amount will not be paid to the Beneficiary. Instead we will pay the Beneficiary:

1. an amount equal to all contributions paid for the increased amount, without interest; plus
2. an amount equal to the amount of Optional Life Benefits that was in effect on the day before the effective date of such increased amount.

Form G.23000-1

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**ACCELERATED LIFE BENEFITS OR DEATH BENEFITS FOR TOTAL AND PERMANENT  
DISABILITY**  
**(On Your Own Account)**

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**A. Definitions**

**"Totally and Permanently Disabled"** means:

1. your life span is drastically limited; and
2. you are expected to die within 12 months; and
3. you are not expected to recover.

These must be certified by a Doctor and accepted by us.

**"Meet the Requirements"** means that, due to a sickness or injury, you are "Totally and Permanently Disabled".

## **B. Coverage**

We will pay Accelerated Benefits to you if:

1. you apply for Accelerated Benefits while your Life Benefits or Death Benefits are in effect; and
2. you Meet the Requirements while you are covered for Life Benefits or Death Benefits; and
3. you or your legal representative requests payment of Accelerated Benefits while your Life Benefits or Death Benefits are in effect.

Accelerated Benefits are payable only once.

Payment of Accelerated Benefits will reduce your Life Benefits or Death Benefits and the amount available for you to convert to a personal policy of life insurance under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

## **C. Proof**

Accelerated Benefits will be payable when we receive proof that you Meet the Requirements.

Proof must be given to us. The proof must be in a form that is satisfactory to us. We have no duty to ask for any proof. Any delay in submitting proof will not cause a claim to be denied so long as the proof is given as soon as reasonably possible.

At the time that such proof is given, we may have you examined by Doctors of our choice, at our expense.

## **D. Amount**

The amount of Accelerated Benefits payable is:

1. up to 50% of your Life Benefits or Death Benefits as shown in the SCHEDULE OF BENEFITS

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a discount for the mortality and interest (\*) for the actuarially determined life span, and

MINUS

an administrative charge not to exceed \$150; and

2. determined as of the date we accept certification that you Meet the Requirements; and
3. no more than \$250,000 for Basic Life Insurance and \$250,000 for Optional Life Insurance.

(\*) The interest rate used shall be the Moody's Corporate Bond Yield Averages - Monthly Average Corporates - published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending two months before the date you apply for an Accelerated Benefit.

If your Life Benefits or Death Benefits are scheduled to reduce within six months of such certification date, we will, for the purpose of determining the amount of Accelerated Benefits, deem the amount of your Life Benefits or Death Benefits to have already been reduced on such certification date.

After payment of the Accelerated Benefits, the amount of your Life Benefits or Death Benefits will be:

1. the amount of Life Benefits or Death Benefits actually in effect on the certification date; less
2. the amount of Accelerated Benefits requested.

When the scheduled reduction date occurs, the amount of your Life Benefits or Death Benefits will be reduced. The amount of such reduction will be determined by applying the percentage in accordance with the provisions of This Plan to the amount of your Life Benefits or Death Benefits actually in effect on the certification date.

After such scheduled reduction, the amount of your Life Benefits or Death Benefits will be the amount of your Life Benefits or Death Benefits actually in effect on the certification date:

REDUCED BY

the amount of such scheduled reduction; and

MINUS

the amount of Accelerated Benefits requested.

Accelerated Benefits will be payable if you are living when payment is made.

For Texas Residents: Upon receipt of your claim form we will send you a Preadjudication letter containing specific information on the payment you requested. Such information will include the amount of payment which will be made to you and the amount of death benefit remaining after payment of the Accelerated Benefit.

#### **E. Exclusions**

Accelerated Benefits will not be payable if:

1. you have assigned your Life Benefits (see Assignment provision under SCHEDULE SUPPLEMENT); or
2. the amount of your Life Benefits or Death Benefits is less than \$10,000.

Form G.23000-36-8

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### **CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY**

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#### **A. Coverage**

If you cease to be Actively at Work as an Employee due to Total Disability, your Life Benefits may be continued for up to 12 months. For this to occur, your Employer must deem you to be Actively at Work and must continue to make premium payments for your Life Benefits. Your Life Benefits will end once you have ceased to be Actively at Work as an Employee due to Total Disability for 12 months. Death Benefits may be payable after your Life Benefits end in certain cases of Total Disability. We will pay Death Benefits to your Beneficiary if:

1. you become Totally Disabled before your Life Benefits end; and
2. your Total Disability starts for Basic Life Benefits while you are covered for such benefits; and
3. you are less than 60 years old when you become Totally Disabled; and
4. you continue to be Totally Disabled after your Life Benefits end and until the date of your death; and

5. you die before you are 65 years old; and
6. the required proof is submitted to us.

However, no Death Benefits are payable if a death benefit is payable under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

## **B. Proof of Claim**

The Death Benefits will be payable when we receive proof of your death if:

1. we have received proof of your Total Disability no later than 12 months after the date you ceased to be Actively at Work because of Total Disability. This proof must establish that your Total Disability had continued for at least nine months from the date you were last Actively at Work; and
2. you submit further proof, when we ask for it, that you continue to be Totally Disabled. We will not ask for such proof more than once a year; and
3. upon your death proof that Total Disability continued to the date of your death is given to us.

If you die within a year after your Life Benefits ended and before any proof has been given, then proof that your Total Disability continued to the date of your death must be given to us. This proof must be given within one year of your death.

All proofs must be given to us. The proofs must be in a form that is satisfactory to us. We have no duty to ask for any proof. If any proof is not given on time, the delay will not cause a claim to be denied so long as the proof is given as soon as reasonably possible.

At any time that proof of your Total Disability is given, we may have you examined by Doctors of our choice, at our expense.

## **C. Amount**

The amount of Death Benefits is the amount of Basic Life Benefits as shown in the SCHEDULE OF BENEFITS.

## **D. Termination**

Your Death Benefits will end on:

1. the date you are no longer Totally Disabled; or
2. the date you do not give us proof of Total Disability when required; or
3. the day before the date you become 65 years old.

## **E. One Payment Only**

If we have issued a personal policy under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE, we will pay Death Benefits only if that policy is returned to us without any claim. In such case an amount equal to the premiums paid on the personal policy will be given to the Beneficiary.

Form G.23000-1B1-A

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## RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE

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### A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or
2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or
3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or
4. the date your Death Benefits end under CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY if you do not then again become eligible for Life Benefits under This Plan.

For New Hampshire residents. If you are not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On Your Own Life at least 15 days before the end of the Application Period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply.

Proof that you are insurable is not required by us.

### B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and
2. it will not take effect until after the Application Period ends; and
3. the premium for the policy will be based on:
  - a. the class of risk to which you belong; and
  - b. your age on the effective date of the policy; and
  - c. the form and amount of the policy; and
4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and
5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:
  - a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and
  - b. \$2,000\*.

\*For New Hampshire residents this amount is \$10,000.

6. if item A(4) applies to you, the amount of the policy will not be more than the amount of your Death Benefits on the date the Life Benefits end.

**C. If You Die During the Application Period**

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) or B(6) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

If you could have applied for a policy under item A(4) and you die within one year after your Life Benefits end, we must, within one year after your death, be given proof that:

1. your Total Disability had continued from the date your Life Benefits ended to within 31 days of the date of your death; and
2. your death occurred during the Application Period which applies to item A(4).

Form G.23000-1A

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**LIFE BENEFITS  
(On Account of Dependents)**

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**A. Coverage**

If a Dependent dies while Life Benefits are in effect for that Dependent, we will pay the amount of Life Benefits that is in effect for that Dependent on the date of that Dependent's death.

**B. Payment of Benefits**

The benefits will be paid to you if you survive the Dependent. The benefits will be paid to your estate if:

1. that Dependent dies at the same time your death occurs; or
2. that Dependent dies within 24 hours of your death.

In any other instance the benefits will be paid to the Dependent's estate; or we may instead pay all or part of the benefits to one or more of the following persons who are related to that Dependent and who survive that Dependent:

- a. parent;
- b. child;
- c. brother and sister.

Any payment will discharge our liability for the amount so paid.

**C. Optional Types of Payment**

Payment of any amount of Life Benefits may be made in installments instead of one sum. Details on the payment options may be obtained from the Employer.

#### D. Suicide

LIFE BENEFITS (On Account of Dependents) will not be paid if a Dependent commits suicide, while sane or insane, within 2 years from the effective date of your LIFE BENEFITS (On Account of Dependents). Instead we will pay an amount equal to any contributions paid, without interest, as set forth in Section B, Payment of Benefits.

If a Dependent commits suicide, while sane or insane, more than 2 years after the effective date of LIFE BENEFITS (On Account of Dependents), but within 2 years from the effective date of any increase in the amount of LIFE BENEFITS (On Account of Dependents), such increased amount will not be paid. Instead we will pay:

- a. an amount equal to all contributions paid for the increased amount, without interest, plus
- b. an amount equal to the amount of LIFE BENEFITS (On Account of Dependents) that was in effect on the day before the effective date of such increased amount,

as set forth in Section B, Payment of Benefits.

Form G.23000-7C

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### **ACCELERATED LIFE BENEFITS FOR TOTAL AND PERMANENT DISABILITY (On Account Of Your Dependent Spouse)**

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#### A. Definitions

**"Totally and Permanently Disabled"** means:

1. your Dependent spouse's life span is drastically limited; and
2. your Dependent spouse is expected to die within 12 months; and
3. your Dependent spouse is not expected to recover.

**"Meets the Requirements"** means, that, due to a sickness or injury, your Dependent spouse is "Totally and Permanently Disabled".

#### B. Coverage

We will pay Accelerated Benefits to you if:

1. you apply for Accelerated Benefits while LIFE BENEFITS (On Account of Dependents) on account of your spouse are in effect; and
2. your Dependent spouse Meets the Requirements while you are covered for LIFE BENEFITS (On Account of Dependents) on account of your spouse; and
3. you request payment of Accelerated Benefits while LIFE BENEFITS (On Account of Dependents) on account of your spouse are in effect.

Accelerated Benefits are payable only once.

Payment of Accelerated Benefits will reduce the amount of LIFE BENEFITS (On Account of Dependents) on account of your spouse and the amount available for your Dependent spouse to convert to a personal policy of life insurance under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT.

**C. Proof**

Accelerated Benefits will be payable when we receive proof that your Dependent spouse Meets the Requirements.

Proof must be given to us. The proof must be in a form that is satisfactory to us. We have no duty to ask for any proof. Any delay in submitting proof will not cause a claim to be denied so long as the proof is given as soon as reasonably possible.

At the time that such proof is given, we may have your Dependent spouse examined by Doctors of our choice, at our expense.

**D. Amount**

The amount of Accelerated Benefits payable is:

1. up to 50% of your LIFE BENEFITS (On Account of Dependents) on account of your spouse as shown in the SCHEDULE OF BENEFITS  
REDUCED BY  
a discount for the mortality and interest (\*) for the actuarially determined life span, and  
MINUS  
an administrative charge not to exceed \$150; and
2. determined as of the date we accept certification that your Dependent spouse Meets the Requirements; and
3. no more than \$250,000.

(\*) The interest rate used shall be the Moody's Corporate Bond Yield Averages - Monthly Average Corporates - published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending two months before the date you apply for an Accelerated Benefit.

If the LIFE BENEFITS (On Account of Dependents) on account of your spouse are scheduled to reduce within six months of such certification date, we will, for the purpose of determining the amount of Accelerated Benefits, deem the amount of the LIFE BENEFITS (On Account of Dependents) on account of your spouse to have already been reduced on such certification date.

After payment of the Accelerated Benefits, the amount of the LIFE BENEFITS (On Account of Dependents) on account of your spouse will be:

1. the amount of LIFE BENEFITS (On Account of Dependents) on account of your spouse actually in effect on the certification date; less
2. the amount of Accelerated Benefits requested.

When the scheduled reduction date occurs, the amount of LIFE BENEFITS (On Account of Dependents) on account of your spouse will be reduced. The amount of such reduction will be determined by applying the percentage in accordance with the provisions of This Plan to the amount of the LIFE BENEFITS (On Account of Dependents) on account of your spouse actually in effect on the certification date.

After such scheduled reduction, the amount of the LIFE BENEFITS (On Account of Dependents) on account of your spouse will be the amount of the LIFE BENEFITS (On Account of Dependents) on account of your spouse actually in effect on the certification date:

REDUCED BY

the amount of such scheduled reduction; and

MINUS

the amount of Accelerated Benefits requested.

Accelerated Benefits will be payable if you are living when payment is made.

For Texas Residents: Upon receipt of your claim form we will send you a Preadjudication letter containing specific information on the payment you requested. Such information will include the amount of payment which will be made and the amount of Dependent Life Benefit remaining after payment of the Accelerated Benefit.

#### **E. Exclusions**

Accelerated Benefits will not be payable if the amount of LIFE BENEFITS (On Account of Dependents) on account of your spouse is less than \$10,000.

Form G.23000-36A-8

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### **RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT**

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#### **A. Application**

We will issue a personal policy of life insurance without disability or accidental death benefits to a Dependent if that Dependent applies for it in writing during the Application Period. The Application Period is the 31 day period after the date the Life Benefits on that Dependent end because:

1. your employment ends or you are no longer in a class which remains eligible for Dependent Life Benefits; or
2. This Plan ends, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or
3. This Plan is changed to end the Dependent Life Benefits for your class, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or
4. you die; or
5. the Dependent no longer qualifies as a Dependent as defined in DEFINITIONS OF CERTAIN TERMS USED HEREIN.

For New Hampshire residents. If the Dependent is not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On The Life of A Dependent at least 15 days before the end of the Application Period, that Dependent will have additional time in which to apply. The Dependent will then have 15 days from the date the Dependent is given the notice in which to apply.

Proof that the Dependent is insurable is not required by us.

**B. Conditions**

The personal policy will be issued to the Dependent subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and
2. it will not take effect until after the Application Period ends; and
3. the premium for the policy will be based on:
  - a. the class of risk to which the Dependent belongs; and
  - b. the Dependent's age on the effective date of the policy; and
  - c. the form and the amount of the policy; and
4. if item A(2) or A(3) applies to the Dependent, the amount of the policy will not be more than the lesser of:
  - a. the amount of Life Benefits on that Dependent on the date the Life Benefits end, less any amount of life insurance on the life of that Dependent for which you or the Dependent may be eligible under any group policy which takes effect within 31 days after the Life Benefits on that Dependent end; and
  - b. \$2,000\*; and

\*For New Hampshire residents this amount is \$10,000.

5. if an item in paragraph A, other than item A(2) or A(3), applies to the Dependent, the amount of the policy will not be more than the amount of Life Benefits on that Dependent on the date the Life Benefits end.

**C. If the Dependent Dies During the Application Period**

If the Dependent dies during the Application Period, we will pay a death benefit. The payment of the death benefit will be in the same manner as if the Life Benefits on that Dependent had been in effect on the date of that Dependent's death. The amount of the death benefit will be the highest amount of life insurance, pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if the Dependent did not apply for a personal policy.

Form G.23000-7A

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**ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

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**A. Coverage**

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; and if:

1. that accident is the sole cause of the injury; and
2. that injury is the sole cause of that Covered Loss; and

3. that Covered Loss occurs not more than one year after the date of that accident.

In addition, we will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown below:

#### Exposure Benefit

We will pay an amount equal to the Full Amount, shown in section B, for the loss of your life if:

- a. such loss of life results from unavoidable exposure to the elements; and
- b. after one year, your body has not been found after the conveyance in which you were traveling:
  - i. disappeared;
  - ii. made a forced landing;
  - iii. sank; or
  - iv. was wrecked.

In addition, we will pay an amount equal to 10% of the Full Amount shown in section B for the loss of your life that results from injuries sustained while driving or riding in a private Passenger Car if your Seat Belt was properly fastened; but the amount payable will not: (a) exceed \$25,000; nor (b) be less than \$1,000.

"Passenger Car" means any validly registered four-wheel private Passenger Car. It does not include:

1. any commercially licensed car; or
2. a private Passenger Car which is being used for commercial purposes.

"Seat Belt" means:

- a. any child restraint device which meets the definition of the state law; or
- b. any other restraint device which:
  - i. meets published federal safety standards;
  - ii. has been installed by the car manufacturer; and
  - iii. has not been altered after such installation.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

We will not pay this benefit if you were driving while under the influence of alcohol or drugs.

#### **B. Maximum Benefit for All Covered Losses in Each Accident**

For all Covered Losses caused by all injuries which you sustain in one accident not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits for which you are covered on the date of your accident.

### C. Table of Covered Losses and Benefit Amounts

<b>Covered Losses (Subject to Exclusions)</b>	<b>Benefit Amounts</b>
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Thumb and Index finger of same hand	One-quarter of the Full Amount
Speech and hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	One-half of the Full Amount
Hemiplegia	One-half of the Full Amount

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

Loss of thumb and index finger means actual severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

### D. Exclusions

We will not pay for any Covered Loss shown in Section C if it in any way results from, or is caused or contributed to by:

1. physical or mental illness, diagnosis of or treatment for the illness; or
2. an infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or
3. suicide or attempted suicide; or
4. injuring oneself on purpose; or

5. the use of any drug or medicine; or
6. a war, or a warlike action in time of peace, including terrorist acts; or
7. committing or trying to commit a felony or other serious crime or an assault; or
8. any poison or gas, voluntarily taken, administered or absorbed; or
9. service in the armed forces of any country or international authority, except the United States National Guard; or
10. operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or
11. driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

**E. Payment of Benefits**

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and
2. to you for any other Covered Loss sustained by you.

**F. Optional Types of Payment**

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

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**BENEFICIARY**

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**A. Your Beneficiary**

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

You may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

**B. More Than One Beneficiary**

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

**C. Death of a Beneficiary**

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or
2. that person dies at the same time your death occurs; or
3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

**D. No Beneficiary at Your Death**

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to your estate. However, we may instead pay all or part of that amount to one or more of the following persons who are related to you and who survive you:

1. spouse;
2. child;
3. parent;
4. brother and sister.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

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**CLAIM PROCEDURE FOR  
ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

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**A. When Notice of Claim Must be Given**

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

**B. Claim Forms**

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

**C. When Proof of Claim Must Be Given**

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

**D. Late Notice or Proof**

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

**E. Time Limits on Starting Lawsuits**

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be started more than 3 years after the time proof must be given.

**F. Medical Examinations**

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

**G. Autopsy**

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

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**WHEN BENEFITS END**

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- A.** For non-contributory benefits, your benefits will end on the date your employment ends. For contributory benefits, your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.
- B.** If This Plan ends in whole or in part, your benefits which are affected will end.
- C.** Your Dependent Life Benefits will end on the earliest of:
1. with respect to your Dependent spouse, the date such Dependent spouse attains age 70; or
  2. the end of the calendar year in which the Dependent ceases to be your Dependent; or
  3. the date you retire, as determined by the Employer; or
  4. the date of your death.

- D. If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

## **PORTABILITY**

For purposes of this subsection, the term "Portability Eligible Insurance for you" refers to Optional Life Insurance.

If insurance is in effect on account of a Dependent, the term "Portability Eligible Dependent Insurance" refers to Life Insurance for Your Dependents.

1. You may request in writing during the Request Period specified below to continue Portability Eligible Insurance for you and Portability Eligible Dependent Insurance under another group policy if such insurance ends because:
  - your employment ends; or
  - you cease to be in a class that is eligible for such insurance.
2. Your Dependent Spouse may request in writing during the Request Period specified below to continue Portability Eligible Dependent Insurance on their life under another group policy if such insurance ends because:
  - you die; or
  - your marriage ends in divorce or annulment.

If a request is made under this subsection, we will issue a new certificate of insurance which will explain the new insurance benefits. The insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

A request for portability may be made, if on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Employer of its intent to end the Group Policy;
- no application has been made to convert the insurance that is to be continued to an individual policy of life insurance as provided in the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE or the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT; and
- The person making the request resides in a jurisdiction that permits portability.

## **Request Period**

To continue Portability Eligible Insurance for you and/or Portability Eligible Dependent Insurance under a different group policy, we must receive a completed request form within the Request Period described below.

If written notice of the option to continue Portability Eligible Insurance for you and/or Portability Eligible Dependent Insurance is given within 15 days before or after the date such insurance ends, the Request Period begins on the date the insurance ends and expires 31 days after such date.

If written notice of the option to continue Portability Eligible Insurance for you and/or Portability Eligible Dependent Insurance is given more than 15 days after but within 90 days of the date such insurance ends, the Request Period begins on the date the insurance ends and expires 45 days after the date of the notice.

If written notice of the option to continue Portability Eligible Insurance for you and/or Portability Eligible Dependent Insurance is not given within 90 days after the date such insurance ends, the Request Period begins on the date the insurance ends and expires at the end of such 90 day period.

### **Amount of the New Certificate**

The maximum amount of Optional Life Insurance which may be continued is the lesser of:

- The total amount of all such insurance for you in effect immediately prior to the date it ends; or
- For residents of all states other than Michigan, \$1,000,000. For residents of Michigan, the maximum amount is limited by law and in 2005, the maximum is \$173,400.

The minimum amount of Optional Life Insurance which may be continued is \$20,000.

The maximum amount of Dependent Life Insurance which may be continued is:

- If you are making the request to continue Portability Eligible Dependent Life Insurance, the lesser of:
  - the amount of such insurance in effect immediately prior to the date it ends; and,
  - the amount of Portability Eligible Life Insurance which is being continued.
- If your Dependent is making the request to continue Portability Eligible Dependent Life Insurance, the amount of such insurance in effect immediately prior to the date it ends.

### **Right to Convert Life Insurance Amounts Not Continued**

Any amount of Life Insurance not continued under this subsection may be converted under the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE or the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT.

### **Premiums for the New Certificate.**

When a request to continue Portability Eligible Insurance for you and/or Portability Eligible Dependent Insurance is made under this subsection, the first premium must be paid during the Request Period. All premium payments must be made directly to us. When we issue the new certificate, we will also provide a schedule of premiums and payment instructions.

### **If You Die Within 31 Days of the Date Your Life Insurance Ends**

If you die within 31 days of the date your life insurance ends and we have not received an application for a new certificate under this section, we will pay Life Insurance in accordance with the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE. If an application for a new certificate was received by us during such time period, we will only pay benefits for the Portability Eligible Insurance for which you applied for in accordance with this subsection.

**If Your Dependent Dies During the Request Period**

If your Dependent dies during the Request Period and an application for a new certificate was not received by us during the Request Period, we will pay Life Insurance in accordance with the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT. If an application for a new certificate was received by us during the Request Period, we will only pay benefits for the Portability Eligible Dependent Insurance applied for in accordance with this subsection.

**If You are Totally Disabled on the Date Your Employment Ends.**

If you are Totally Disabled on the date your employment ends and you elect to continue Portability Eligible Insurance for you as provided in this subsection, you may at a later date become approved for the continuation of such insurance under the section entitled CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY. If you are so approved, any insurance described in, applied for, or issued under this subsection will end and we will return any premium paid by you for such insurance.

**OPTION TO CONVERT**

In addition to the continuation of insurance option described above, you may have the right to convert to a policy of individual life insurance. We urge you to read the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE or the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT.

Form G.23000-F

END-EPORT

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**CONDITIONS UNDER WHICH YOUR ACTIVE  
WORK IS DEEMED TO CONTINUE**

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If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

**Your Sickness or Injury, Your Leave of Absence, Your Lay Off**

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class. However, the period will not be longer than two months following the date the leave of absence or layoff begins.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) or a similar state law, the period cannot be longer than the leave required by law. If a leave qualified under more than one such law, the period cannot be longer than the longest leave permitted under any of the laws.

Form G.23000-L

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## NOTICES

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This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

**Our Home Office is located at 200 Park Avenue, New York, New York 10166.**

Form G.23000-E

**THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.**

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## ERISA INFORMATION

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### **NAME OF THE PLAN**

Trinity Health Life Insurance Plan, ("Plan").

### **NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR**

Trinity Health Corporation  
27870 Cabot Drive  
Novi, Michigan 48337-2920

### **EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER**

35-1443425

505

### **TYPE OF PLAN**

Employee Welfare Plan including:

Life Benefits  
Accidental Death or Dismemberment Benefits

### **TYPE OF ADMINISTRATION**

The above listed benefits are insured by Metropolitan Life Insurance Company, ("MetLife").

### **AGENT FOR SERVICE OF LEGAL PROCESS**

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

### **ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS**

Your MetLife certificate describes the eligibility requirements for insurance under the Plan. It also includes a detailed description of insurance provided by MetLife under the Plan.

### **PLAN TERMINATION OR CHANGES**

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your coverage ends in accord with the "When Benefits End" provision of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

## **CONTRIBUTIONS**

There are benefits insured under the group insurance coverages or the group insurance policy or policies which are combined for experience. This means that the costs of these coverages are determined on a combined basis, and the costs are accumulated from year to year. As a result, favorable experience under one or more coverage in a particular year may offset unfavorable experience on other coverages in the same year, or offset unfavorable experience of coverage in prior years.

The optional life insurance benefits are not combined for experience with the other insurance coverages.

No contribution is required for Basic Life and Accidental Death or Dismemberment Benefits.

You must make a contribution to the cost of Optional Life and Dependent Life Benefits.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

## **PLAN YEAR**

The Plan's fiscal records are kept on a Plan year basis beginning each January 1 and ending on the following December 31.

## **QUALIFIED DOMESTIC RELATIONS ORDERS / QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

## **CLAIMS INFORMATION**

### **Procedures for Presenting Claims for Life and Accidental Death or Dismemberment Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims.

### **Life and Accidental Death or Dismemberment Benefits Claims**

#### **Routine Questions**

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

#### **Claim Submission**

In submitting claims for Life and Accidental Death or Dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

#### **Initial Determination**

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

### **Appealing the Initial Determination**

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

## **Claims Involving Disability Determinations in connection with Life and Accidental Death or Dismemberment Insurance**

### **Routine Questions**

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

### **Claim Submission**

For any claim which requires a determination of disability in connection with Life and Accidental Death or Dismemberment insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. For example, if your Plan provides that you are not required to continue paying for your life insurance coverage after you are found to be disabled, or if your plan provides that a portion of your life insurance benefits are payable to you after you are found to be disabled, your request for such determination is treated as a claim involving a disability determination.

Claim forms must be submitted in accordance with the instructions on the claim form.

Please note that for some plans such claims involving disability determinations are decided by employers. If that is the case for your plan, your employer rather than MetLife may administer the procedures below.

### **Initial Determination**

After MetLife receives your claim involving a disability determination, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

### **Appealing the Initial Determination**

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time

MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

### **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

### **STATEMENT OF ERISA RIGHTS**

The following statement is required by federal law and regulation.

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

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts 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 Pension and Welfare Benefit Administration.

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

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

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

#### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

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### **FUTURE OF THE PLAN**

It is hoped that the Plan will be continued indefinitely, but Trinity Health Corporation reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Trinity Health Corporation shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

## **Supplementary ERISA Information For Legal Services Insurance – Will Preparation Benefit**

The ERISA information set forth above which pertains to Group Supplemental Life Insurance also applies to Legal Services Insurance – Will Preparation Benefit, except as noted below:

### Coverage

Legal Services Insurance – Will Preparation Benefit

### Type of Administration

Legal Services Insurance – Will Preparation Benefit is insured by Metropolitan Property and Casualty Insurance Company (“Metropolitan”). In either case, benefits are administered by Hyatt Legal Plans, Inc.

### **Agent for Service of Legal Process**

For disputes arising under those portions of the Plan insured by Metropolitan Property and Casualty Insurance Company (“Metropolitan”), service of legal process may be made upon Metropolitan (Hyatt Legal Plans, Inc. in Florida) at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

### **Eligibility For Insurance; Description or Summary of Benefits**

Your Metropolitan Property and Casualty Insurance Company (“Metropolitan”) certificate describes the eligibility requirements for insurance under the Plan. It also includes a detailed description of the insurance provided by Metropolitan Property and Casualty Insurance Company (“Metropolitan”) under the Plan.

### **Plan Termination or Changes**

The Group Legal Services policy sets forth those situations in which the Employer and/or Metropolitan Property and Casualty Insurance Company (“Metropolitan”) have the right to end the Group Legal Services policy.

### **Contributions**

No contribution is required for Legal Services Insurance – Will Preparation Benefit.

### **Claims Information**

Claims information for Legal Services Insurance – Will Preparation Benefit is contained under the subsection “How the Group Legal Services Plan Works” in the Legal Services Plan Certificate of Coverage.

**For information about the Will Preparation Service, you may contact  
the provider, Hyatt Legal Plans, Inc. by phone.**

**Phone: 1-800-821-6400**