

# Group Insurance Plan

**UNDERWRITTEN BY:**  
**CIGNA LIFE INSURANCE COMPANY OF NEW YORK**  
a New York Life Insurance company

Class 1  
06/2024

# Cornell University





The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

ER-03-2

## FOREWORD

**Disability** insurance provides individuals and their families with financial protection. The **Disability** Insurance Benefit described in this booklet will help secure your family's financial security in the event of your disability.

The need for disability insurance protection depends on individual circumstances and financial situations. This valuable coverage should add an extra dimension to your personal insurance portfolio.

Insurance benefits described in the following pages will apply to you if your Employer has made this coverage available to you at no cost or you have elected the benefit and authorized payroll deduction for the required premium.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company's written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.

**Appeal Procedure for Denied Claims** (applies to all claims filed before April 1, 2018)

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days ( in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

**INA LIFE INSURANCE COMPANY OF NEW YORK**  
140 EAST 45TH STREET  
NEW YORK, NY 10017-3144  
(800) 732-1603  
**A STOCK INSURANCE COMPANY**

**GROUP INSURANCE  
CERTIFICATE**  
TDD (800) 552-5744

We, the INA LIFE INSURANCE COMPANY OF NEW YORK, certify that we have issued a Group Policy, NYK-030029, to Cornell University.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Policy. Your coverage will begin and end according to the terms set forth in this certificate.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.



Scott Berlin, President

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

**Claims for Benefits** (applies to all claims filed before April 1, 2018)

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

## CIGNA LIFE INSURANCE COMPANY OF NEW YORK

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

**Appeal of Denied Non-Disability Claims** (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

### NAME CHANGE ENDORSEMENT

Effective July 19, 1999, this endorsement is attached to and made a part of your INA Life Insurance Company of New York certificate.

The name CIGNA Life Insurance Company of New York replaces the name INA Life Insurance Company of New York wherever the name is used. All other terms and conditions of the certificate remain the same.

CIGNA Life Insurance Company of New York has, by its President, executed this Change of Name Endorsement as of July 19, 1999.

CIGNA LIFE INSURANCE COMPANY OF NEW YORK



Scott Berlin, President

8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

**Claims for Non-Disability Benefits** (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.



## TABLE OF CONTENTS

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;

SCHEDULE OF BENEFITS FOR CLASS 1	1
WHO IS ELIGIBLE	3
WHEN COVERAGE BEGINS	4
WHEN COVERAGE ENDS	4
CONTINUATION OF INSURANCE	5
WHAT IS COVERED	5
WHAT IS NOT COVERED	14
CLAIM PROVISIONS	15
ADMINISTRATIVE PROVISIONS	18
GENERAL PROVISIONS	19
DEFINITIONS	21

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

## SCHEDULE OF BENEFITS FOR CLASS 1

8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

**Appeal of Denied Disability Claims** (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

**Policy Effective Date:** January 1, 2000

**Certificate Effective Date:** January 1, 2024

**Policy Anniversary Date:** January 1

**Policy Number:** NYK-030029

**Eligible Class Definition:** All Employees of Cornell University, who are scheduled to work a minimum of 1000 hours or more per calendar year or who worked 1000 hours or more a year during the immediately preceding calendar year.

### **Eligibility Waiting Period**

If you are a Full-time Employee working more than half-time and were hired on or before the **Policy Effective Date:** No Waiting Period.

If you are a Part-time Employee working half-time and were hired on or before the **Policy Effective Date:** After 3 years of Active Service.\*

If you are a Full-time Employee working more than half-time and were hired after the **Policy Effective Date:** No Waiting Period.

If you are a Part-time Employee working half-time and were hired after the **Policy Effective Date:** After 3 years of Active Service.\*

\*If you are working half-time and become a Full-time Employee, you will be eligible on the date you become a Full-time Employee.

**Benefit Waiting Period** 180 days

**Disability Benefit** The lesser of 60% of your monthly **Covered Earnings** rounded to the nearest dollar or your Maximum **Disability Benefit**, reduced by any Other Income Benefits.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf.

**Maximum Disability Benefit** \$20,000 per month

**Minimum Disability Benefit** \$100 per month

**Maximum Benefit Period**

The later of your SSNRA\* or the Maximum Benefit Period listed below.

<u>Age When Disability Begins</u>	<u>Maximum Benefit Period</u>
Under Age 60	Your 65th birthday.
Age 60 and over	The end of 5 years from the date you became Disabled.

\*SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.

TY-005159

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

**Claims for Disability Benefits** (applies to all claims filed on or after April 1, 2018)

A disability “claim” is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is “filed” as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company’s intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant’s name and address, and the group Policy holder’s name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company’s decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant’s response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

**WHO IS ELIGIBLE**

**Employee Eligibility**

If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the **Policy Effective Date**, or the day after you complete the Eligibility Waiting Period, if later.

If you have previously converted your insurance under the Policy, you will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in your **Disability** Insurance benefits based on age or a change in class unless those conditions no longer effect the amount of coverage available to you.

Except as noted in the Reinstatement Provision, if you terminate your coverage and later wish to reapply, or if you are a former **Employee** who is rehired, you must satisfy a new Eligibility Waiting Period. You are not required to satisfy a new Eligibility Waiting Period if your insurance ends because you are no longer in an eligible class, but you continue to be employed by the **Employer** and within one year you become a member of an eligible class. You are also not required to satisfy a new Eligibility Waiting Period if you change from eligible **Full-time** to eligible part-time status.

You must be in **Active Service** throughout the Eligibility Waiting Period to be eligible for coverage. The Eligibility Waiting Period will be extended by the number of days you are not in **Active Service**.

TY-005154-1

## WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

If you are required to contribute to the cost of your insurance you may elect to be insured only by authorizing payroll deduction in a form approved by the **Employer** and us. The effective date of your insurance depends on the date coverage is elected.

If you elect coverage within 31 days after you become eligible, your insurance is effective on the latest of the following dates.

1. The **Policy Effective Date**.
2. The date you authorized payroll deduction for this insurance.
3. The date the completed enrollment request is received by the **Employer** or us.

If you are not in **Active Service** on the date your insurance would otherwise be effective, it will be effective on the date you return to **Active Service**.

TY-005155-1

## WHEN COVERAGE ENDS

Your insurance ends on the earliest of the dates below.

1. The date you are eligible for coverage under a plan intended to replace this coverage.
2. The date the Policy is terminated.
3. The date you no longer qualify under your Class Definition.
4. The day after the period for which premiums are paid.
5. The date you are no longer in **Active Service**.

TY-005156

## Assistance with Your Questions

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

## WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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.

## CONTINUATION OF INSURANCE

### Continuation of Disability Insurance

Your **Disability** Insurance will continue if your **Active Service** ends because of a **Disability** for which benefits under the Policy are or may become payable. Your premiums will be waived while **Disability** Benefits are payable. If you do not return to **Active Service**, your **Disability** Insurance will end when you are no longer **Disabled** or when benefits are no longer payable, whichever occurs first.

### Continuation for Leave of Absence

If your **Active Service** ends because you take an **Employer** approved unpaid leave of absence, we will continue your insurance for up to one semester/six months if the required premium is paid.

If your insurance continues and you become **Disabled** during the leave of absence, **Disability** Benefits will not begin until you satisfy your Benefit Waiting Period, or the date you are scheduled to return to **Active Service**, if later.

TY-005157-1 (30029)

## DESCRIPTION OF BENEFITS WHAT IS COVERED

### Disability Benefits

If you become **Disabled**, as we define the term in the Definitions section, while you are covered under the Policy, we will pay you **Disability** Benefits. After you are **Disabled**, you must satisfy the Benefit Waiting Period and be under the care and treatment of a **Physician**. Also, we ask you to provide us with satisfactory proof of your **Disability**, at your expense, before benefits will be paid.

We will require continued proof of your **Disability** for benefits to continue.

### **Benefit Waiting Period**

The Benefit Waiting Period is the period of time you must be continuously **Disabled** before **Disability** Benefits may be payable. Your Benefit Waiting Period is shown in the Schedule of Benefits.

We will not require you to satisfy the Benefit Waiting Period if benefits were payable to you under a **Prior Plan** on the **Policy Effective Date** and you return to **Active Service** within 6 months after this Effective Date and are **Disabled** again within 14 days. Your later period of **Disability** must be caused by the same or related causes for your Benefit Waiting Period to be waived.

### **Trial Work Days**

Under this plan, you can attempt to return to **Active Service** without having to start a new Benefit Waiting Period if you cannot continue working. A period of **Disability** is continuous even if you can return to **Active Service** for an unlimited number of days during the Benefit Waiting Period. Your Benefit Waiting Period will not be extended by the number of days you returned to **Active Service** during this period.

### **Termination of Your Disability Benefits**

Your **Disability** Benefits will end on the earliest of the dates listed below.

1. The date you earn more than 80% of your **Indexed Covered Earnings**.
2. The date we determine you are no longer **Disabled**.
3. The date the Maximum Benefit Period ends.
4. The date you die.
5. The date you return to **Active Service**.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employer and Employees.
- The date of the end of the Plan Year is December 31.

### **YOUR RIGHTS AS SET FORTH BY ERISA**

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

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

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

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

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



**SUPPLEMENTAL INFORMATION  
for**

**Cornell University (“Plan”)**

**required by the Employee Retirement  
Income Security Act of 1974**

As a Plan participant in Cornell University's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

**IMPORTANT INFORMATION ABOUT THE PLAN**

- The Plan is established and maintained by Cornell University, the Plan Sponsor.
- The Employer Identification Number (EIN) is 15-0532082.
- The Plan Number is 508.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, NYK-030029 (“Policy”), issued by CIGNA LIFE INSURANCE COMPANY OF NEW YORK (“Insurance Company”).
- The Plan Administrator is:       Cornell University  
  395 Pine Tree Road, Suite 130  
  Ithaca, NY 14850  
  607-255-7074
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.

**Successive Periods of Disability**

Once you are eligible to receive **Disability** Benefits under the Policy, separate periods of **Disability** resulting from the same or related causes are a continuous period of **Disability** unless you return to **Active Service** for more than 6 consecutive months.

A period of **Disability** is not continuous if separate periods of **Disability** result from unrelated causes, or your later **Disability** occurs after your coverage under the Policy ends.

The Successive Periods of **Disability** provision will not apply if you are eligible for coverage under a plan that replaces the Policy.

**Pre-Existing Condition Limitation**

We will not pay **Disability** Benefits for any period of **Disability** which is caused by, or contributed from, or results from a Pre-Existing Condition. A "Pre-existing Condition" means any **Injury** or **Sickness** for which you incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a **Physician** within 12 months before your most recent effective date of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. The Pre-existing Condition Limitation will not apply to the increase in benefits and change in the Definition of **Disability/Disabled** for Class 1 **Employees** which were effective September 1, 2001.

This limitation will not apply to a period of **Disability** that begins more than 12 months after your most recent effective date of insurance or to the change in the Definition of **Disability/Disabled** or the Maximum **Disability** Benefit which are effective September 1, 2001.

Except for any amount of benefit in excess of a **Prior Plan's** benefits, this limitation will not apply if you were covered under a **Prior Plan** and satisfied the Pre-existing Condition Limitation, if any, under that plan. If you were covered under a **Prior Plan**, but did not fully satisfy the Pre-existing Condition Limitation of that plan, we will credit you for any time you did satisfy. Time will not be credited for any day you were not in **Active Service** or were not actively at work due to **Sickness**.

### **Disability Benefit Calculation**

Your **Disability** Benefit for any month **Disability** Benefits are payable to you is shown in the Schedule of Benefits. We base our calculation of **Disability** Benefits on a 30 day period. Benefits will be prorated if payable for any period less than a month.

### **Work Incentive Benefit**

For the first 12 months you are eligible for a Disability Benefit, your **Disability** Benefit is as defined in the Schedule of Benefits. If, for any month during this period, the sum of your **Disability** Benefit, your current earnings and any additional Other Income Benefits exceed 100% of your **Indexed Covered Earnings**, your **Disability** Benefit will be reduced by the excess amount.

After 12 months, your **Disability** Benefit is as shown in the Schedule of Benefits, reduced by 50% of your current earnings received during any month you return to work. If the sum of your **Disability** Benefit, your current earnings any additional Other Income Benefits exceed 80% of your monthly **Indexed Covered Earnings**, your **Disability** Benefit will be reduced by the excess amount.

If you are working for another employer on a regular basis when **Disability** begins, your earnings will include the amount of any increase in the amount you are earning from this work while you are **Disabled**.

### **Sickness**

The term **Sickness** means a physical or mental illness. It also includes pregnancy.

TY-005153-1

**Insurance Company**

The **Insurance Company** underwriting the Policy is INA Life Insurance Company of New York. References to the **Insurance Company** have been changed to "we", "our", "ours", and "us" throughout the certificate.

**Insured**

You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, any applicable **Insurability Requirement** is met, the required premium is paid and your insurance is in force under the Policy.

**Physician**

**Physician** means a licensed doctor practicing within the scope of their license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings or spouses of any of the foregoing, whether related by blood or marriage) of either you or your spouse, or a person living in your household.

**Policy Anniversary**

A **Policy Anniversary** is the date so stated on the Policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

**Policy Effective Date**

The **Policy Effective Date** is the date so stated on the Policy cover.

**Prior Plan**

The **Prior Plan** refers to the plan of insurance providing similar benefits sponsored by the **Employer** in effect directly prior to the **Policy Effective Date**.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued **Disability**.

**Other Income Benefits**

While you are **Disabled**, you may be eligible to receive benefits from other income sources. If so, we may reduce the **Disability** Benefits payable to you under the Policy by the amount of these Other Income Benefits. The extent to which Other Income Benefits will reduce your **Disability** Benefits is shown in the Amounts of Insurance section of the Schedule of Benefits.

Other Income Benefits include:

1. any amounts you receive (or are assumed to receive\*) under:
  - a. the Canada and Quebec Pension Plans;
  - b. the Railroad Retirement Act;
  - c. any local, state, provincial or federal government disability or retirement plan or law as it pertains to your **Employer** (not including Social Security retirement benefits);
  - d. any sick leave or salary continuance plan of your **Employer**;
  - e. any work loss provision in any mandatory "No-Fault" auto insurance;
  - f. any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits;
  - g. any bonus, vacation pay or severance plan of the Employer.

2.
  - a. any Social Security disability benefits you or any third party receive (or are assumed to receive\*) on your behalf; and
  - b. any Social Security retirement benefits you or any third party receive on your behalf.
3. any retirement plan benefits funded by your **Employer**. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by your **Employer**. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any **Employee** savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 403(b) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for **Disability**, and contains the same or similar provision for reduction because of other insurance, we will pay our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
6. any wage or salary for work performed while **Disability** Benefits are payable, to the extent they exceed the amount allowed under the Work Incentive Benefit.

\*See the Assumed Receipt of Benefits provision.

### **Employer**

The Policyholder and any affiliates or subsidiaries covered under the Policy. The **Employer** is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the **Employer** as actions of the **Insurance Company**.

### **Full-time**

Full-time means the number of hours set by the **Employer** as a regular work day for **Employees** in your eligibility class.

### **Indexed Covered Earnings**

For the first year you are **Disabled**, your **Indexed Covered Earnings** will be equal to your **Covered Earnings**. After you have been **Disabled** for 1 year, your **Indexed Covered Earnings** will be your **Covered Earnings** plus an increase applied on each annual anniversary of the date you became **Disabled**. The amount of each increase will be the lesser of:

1. 10% of your **Indexed Covered Earnings** during the preceding year of **Disability**; or
2. the rate of increase in the **Consumer Price Index (CPI-W)** during the preceding calendar year.

### **Injury**

Any bodily harm, including all related conditions and recurring symptoms of the injuries, that results directly or indirectly from an Accident and independently of all other causes.

### **Insurability Requirement**

You will be considered to have satisfied the **Insurability Requirement** on the day we agree in writing to accept you as covered under the Policy. To determine a person's acceptability for insurance, we will require evidence of good health and may require it be provided at your own expense.

### **Covered Earnings**

**Covered Earnings** means your annual wage or salary as reported by the **Employer** for work performed for the **Employer** as in effect just prior to the date your **Disability** begins. **Covered Earnings** are determined initially on the date an **Employee** applies for coverage. A change in the amount of **Covered Earnings** is effective on the date of the change, if the **Employer** gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your **Covered Earnings** will not be effective during a period of continuous **Disability**.

### **Disability/Disabled**

For purposes of coverage under the Policy, you will be considered **Disabled** if, because of **Injury** or **Sickness**, you are unable to perform all the material duties of your regular occupation, or solely due to **Injury** or **Sickness**, you are unable to earn more than 80% of your **Indexed Covered Earnings**.

After **Disability** Benefits have been payable for 24 months, you will be considered **Disabled** if your **Injury** or **Sickness** makes you unable to perform all the material duties of any occupation for which you may reasonably become qualified based on education, training or experience.

### **Employee**

For eligibility purposes, you are an **Employee** if you work for the **Employer** and are in one of the "Classes of Eligible **Employees**." Otherwise, you are an **Employee** if you are an employee of the **Employer** who is insured under the Policy.

### *Increases in Other Income Benefits*

After we make the first deduction for any Other Income Benefits, any cost of living increases for Other Income Benefits, except for wage or salary, will not further reduce your **Disability** Benefit during a period of **Disability**.

### *Lump Sum Payments*

Other Income Benefits or earnings that are paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated monthly over a five-year period.

If no specific allocation of a lump sum payment is made, we will assume the total payment is an Other Income Benefit.

### *Assumed Receipt of Benefits*

We will assume you are receiving Other Income Benefits if you are eligible to receive them. We will estimate the amount of these assumed benefits on the basis of what you may be eligible to receive.

We will not assume your receipt of Other Income Benefits if you give us proof of the following events.

1. Application was made for these benefits.
2. Reimbursement Agreement is signed by you.
3. Any and all appeals were made for these benefits, or we have determined further appeals will not be successful.
4. Payments were denied.

We will not assume you have received, nor will we reduce your **Disability** Benefits by, any elective, actuarially reduced, or early retirement benefits under such laws until you actually receive them.

## *Social Security Assistance*

We will, at our own discretion, assist you in applying for Social Security **Disability** Income (SSDI) benefits. **Disability** Benefits will not be reduced by your assumed receipt of SSDI benefits while you participate in the Social Security Assistance Program.

We may require you to file an appeal if we believe a reversal of a prior decision is possible. If you refuse to participate in, or cooperate with, the Social Security Assistance Program, we will assume receipt of SSDI benefits until you give us proof that you have exhausted all the administrative remedies available to you.

### **Minimum Benefit**

We will pay the Minimum Benefit regardless of any reductions made for Other Income Benefits. However, if there is an overpayment due, this benefit may be reduced to recover the overpayment.

### **Recovery of Overpayment**

If we overpay your benefits, we have the right to recover the amount overpaid by either requesting you to pay the overpaid amount in a lump sum or by reducing any amounts payable to you by the amount due. If there is an overpayment due when you die, we will reduce any benefits payable under the Policy to recover the overpayment.

TY-005183-1 (30029)

## **DEFINITIONS**

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

### **Active Service**

If you are an **Employee**, you are in **Active Service** on a day which is one of your **Employer's** scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the **Employer** on a Full-time basis, either at one of the **Employer's** usual places of business or at some location to which the **Employer's** business requires or authorizes you to travel.
2. The day is a scheduled holiday, vacation day or period of **Employer** approved paid leave of absence.

You are in **Active Service** on a day which is not one of the **Employer's** scheduled work days only if you were in **Active Service** on the preceding scheduled work day.

### **Appropriate Care**

**Appropriate Care** means the determination of an accurate and medically supported diagnosis of your **Disability** by a **Physician**, or a plan established by a **Physician** of ongoing medical treatment and care of your **Disability** that conforms to generally accepted medical standards, including frequency of treatment and care.

### **Consumer Price Index (CPI-W)**

The **Consumer Price Index** for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor.

### **Assignment**

The **Insurance Company** will not be affected by any assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the **Insurance Company**. We do not assume responsibility for the validity or sufficiency of an assignment. An assignment of the certificate will operate so long as the assignment remains in force. To the extent provided under the terms of the assignment, an assignment will transfer all rights and obligations of the Insured, or of the owner if other than the **Employee**.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where it is contrary to law.

### **Conformity with State Statutes**

Any provision of the Policy in conflict on the **Policy Effective Date** with the laws of the state where the Policy is delivered is amended to conform to the minimum requirements of such laws.

### **Clerical Error**

Your coverage will not be affected by error or delay in keeping records of insurance under the Policy. If such an error or delay is found, the premium will be adjusted fairly.

### **Agency**

The Policyholder, **Employer** and plan administrator are agents of the **Employee** for transactions relating to insurance under the Policy. The **Insurance Company** is not liable for any of their acts or omissions.

TY-005182-1

## **ADDITIONAL BENEFITS**

### **Rehabilitation During A Period of Disability**

If you are **Disabled** and we determine that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. We must agree on the terms and conditions of the Rehabilitation Plan.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

A "Rehabilitation Plan" is a written agreement between you and us in which we agree to provide, arrange or authorize vocational or physical rehabilitation services.

TY-005189-1

### **Conversion Privilege**

If your insurance ends because you are no longer employed by the **Employer**, or you are laid off or on an uninsured leave of absence, you may be eligible for long term disability conversion insurance. To be eligible, you must have been insured for **Disability** Benefits and actively at work for at least 12 months. You must apply for conversion insurance within 62 days after your insurance ends.

The benefits of the conversion plan will be those benefits offered at the time you apply. The premium will be based on the rates in effect for conversion plans at that time.

You may not convert your insurance if any of the following conditions apply to you.

1. You are retired or age 70 or older.
2. You are not in **Active Service** because of **Disability**.
3. The Policy is canceled for any reason.
4. You are no longer in a Class of Eligible Persons, but are still employed by the **Employer**.

TY-005184

### **Survivor Benefit**

We will pay a Survivor Benefit if you die while **Disability** Benefits are payable and at least 6 Monthly Benefits have been payable to you for a continuous period of **Disability**. The Survivor Benefit will equal 100% of the sum of the last full **Disability** Benefit payable to you plus any current earnings by which the **Disability** Benefit was reduced for that month. These benefits will be payable for 6 months.

We will pay the Survivor Benefit to your Spouse. If you do not have a Spouse, we will pay your surviving Children in equal shares. If you do not have a Spouse or any Children, we will pay your estate.

"Spouse" means your lawful spouse. "Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.

TY-005191

### **WHAT IS NOT COVERED**

We will not pay any **Disability** Benefits for a **Disability** Benefit that results, indirectly or directly, from:

1. suicide, attempted suicide, or self-inflicted injury.
2. war or any act of war, whether or not declared.
3. **Injury** or **Sickness** while you are serving on full-time active duty in any armed forces. If you send proof of service, we will refund pro rata the premium paid to cover you during a period of such service.

We will not pay **Disability** Benefits for a **Disability** that results directly from the commission of a felony or attempted felony.

### **GENERAL PROVISIONS**

#### **Entire Contract**

The Policy, the application of the Policyholder, a copy of which is attached, the Policyholder endorsements, riders and attached papers constitute the entire contract between the parties. If an application of any **Employee** is required, it may also be made a part of this contract at our option.

#### **Incontestability**

All statements made by the Policyholder, or by an **Employee** are deemed representations and not warranties. No such statement will cause us to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to such person; or in the event of your death or incapacity, your beneficiary or representative.

After two years from the **Employee's** effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested.

#### **Misstatement of Age**

If your age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

#### **Workers' Compensation Insurance**

The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance.



## ADMINISTRATIVE PROVISIONS

### Premiums

The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

### Reinstatement of Insurance

Your insurance may be reinstated if your insurance ends because you are on an unpaid leave of absence, refuse to participate in rehabilitation efforts, or are not receiving **Appropriate Care**.

Your insurance may be reinstated only if reinstatement occurs within 12 months from the date your insurance ends. For your insurance to be reinstated all of the following conditions must be met.

1. You must be in a Class of Eligible **Employees**.
2. The required premium must be paid.
3. A written request, or a request by any other telephonic or electronic means authorized by the **Employer** and the **Insurance Company**, for reinstatement must be received by us within 31 days from the date you return to **Active Service**.

Your reinstated insurance is effective on the date you return to **Active Service** if the required premium is paid. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation before your insurance ended, you will receive credit for any time that was satisfied.

TY-005180-1 (30029)

We will not pay **Disability** Benefits for any period of **Disability** during which you:

1. are incarcerated in a penal or corrections institution for any reason.
2. are not receiving **Appropriate Care**.
3. fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit due.

TY-005177-1 (30029)

## CLAIM PROVISIONS

### Notice of Claim

Written notice of claim or notice by any other electronic or telephonic means authorized by the **Insurance Company**, must be given to us within 31 days after a covered loss occurs or begins, or as soon as reasonably possible. If this notice is not given in that time, the claim will not be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. Written notice can be given at our home office in New York, New York, or to our agent. Notice should include the Policyholder's name, the Policy number and the claimant's name and address.

### Claim Forms

When we receive the notice of claim, we will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof or proof by any other electronic or telephonic means authorized by us, of the nature and extent of the loss.

### **Claimant Cooperation Provision**

If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

### **Insurance Data**

The **Employer** is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the **Employer** in these areas is confidential and may not be used or released by the **Employer** if not permitted by applicable laws.

### **Proof of Loss**

Written proof, or proof by any other electronic/telephonic means authorized by us, that **Disability** continues and of **Appropriate Care** by, or regular attendance by a **Physician** must be given to us at intervals required by us. Within 30 days of a request, such proof of continued **Disability** must be furnished to us.

We will not deny or reduce any claim if it: 1) is not reasonably possible to furnish the required proof within that period; and 2) is shown that such proof of loss was given as soon as was reasonably possible.

### **Time of Payment**

**Disability** Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.

### **To Whom Payable**

Any benefits that are payable for **Disability** will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion, is not able to give a valid receipt, such payment will be made to their legal guardian.

If you die while any **Disability** Benefits remain unpaid, we may, at our option, make direct payment to the first surviving class of the following living relatives: spouse, children, parents, brothers and sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

### **Physical Examination and Autopsy**

We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

### **Legal Actions**

No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic or telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time written proof of loss is required to be furnished.

### **Time Limitations**

If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

### **Physician/Patient Relationship**

You have the right to choose any **Physician** who is practicing legally. We will in no way disturb the **Physician**/patient relationship.

TY-005178-1