ShelterPoint Life Insurance Company
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GROUP VISION CARE INSURANCE CERTIFICATE
ROSTER – FLEXLINE

In this Certificate, SHELTERPOINT LIFE INSURANCE COMPANY may be referred to as ShelterPoint Life, the Company, or We, Us, or Our.

POLICYHOLDER:	VALLEY STREAM TA WELFARE FUND
GROUP POLICY NUMBER:	GVNY26893
GOVERNING JURISDICTION:	New York
EFFECTIVE DATE:	12:01 a.m. Eastern Standard Time on 10/1/2015.

This Certificate shows that You are covered under the Policy. This Certificate is not the Policy. Your coverage is subject to the provisions, terms and conditions of the Policy. Only the Policy governs the terms of Your coverage. You may inspect the Policy at the Policyholder's office during regular business hours.

The Company will pay benefits to insured persons in accordance with the terms of the Policy.

This Certificate provides only vision benefits at limits shown in the Schedule of Benefits. The insurance evidenced by this Certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance as defined by the New York State Department of Financial Services.

Signed for ShelterPoint Life Insurance Company at its home office on the Policy Effective Date.

Constantine T. Lappas
Executive Vice President & Chief Operating Officer

Richard A. White
Chief Executive Officer

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SCHEDULE OF BENEFITS

The Company will pay benefits for Covered Services received by the Insured from a licensed Vision Provider, subject to the conditions of the Policy. Payment of benefits is limited to the maximum amount and frequency of Covered Services set forth in this Certificate. There will be no benefit payable for services and materials that are not specifically included as a Covered Service in this Schedule of Benefits.

Insureds may select a Vision Provider of their choice who is a Participating Provider or a Non-Participating Provider. Benefits under this Certificate will be determined and paid according to whether the Insured selects a Participating or a Non-Participating Provider, and based on the plan selected by the Policyholder. Covered expenses may be different for Participating (in-network) and Non-Participating (out-of-network) Providers.

The out-of-network benefit allowance shown in the Schedule of Benefits is the maximum amount of benefit payable to the Insured for the corresponding Covered Service. The out-of-network benefit will be the lesser of the actual amount charged for the Covered Service or the allowance for the corresponding Covered Service. We will never pay more than the amount charged for a Covered Service.

CUSTOM PLAN		
BENEFIT FREQUENCY		
VISION EYE EXAMINATION AND EYEWEAR		
Eye health examination (Vision Survey and/or Vision Analysis) - inclusive of testing and dilation when professionally indicated	Once per Benefit Year	
Frame	Once per Benefit Year	
Lenses	Once per Benefit Year	
Medically Necessary contact lenses (in lieu of eyeglasses - frame and lenses)	Once per Benefit Year	
Elective contact lenses (in lieu of eyeglasses - frame and lenses)	Once per Benefit Year	
Contact lens evaluation and fitting (in lieu of eyeglasses - frame and lenses)	Once per Benefit Year	
IN-NETWORK BENEFITS		
COVERED SERVICE	**AMOUNT DUE PER COVERED SERVICE**	
1. EYE EXAMINATION	No charge	
2. LENSES a. Standard glass or plastic lenses	Single vision	No charge
	Bifocal	No charge

	Intermediate Vision Lenses	No charge
	Trifocal	No charge
	Lenticular	No charge
b. Lens options	Scratch-Resistant Coating (Standard)	$10 Copay – No charge after Copay
	Polycarbonate – Dependent children to age 26, Monocular patients, Patients with Prescription +/- 6.00 Diopters or greater *Prior authorization required*	$20 Copay – No charge after Copay
	UV Coating	$10 Copay – No charge after Copay
	Anti-Reflective Coating - available per NVA formulary Standard	$33 Copay – No charge after Copay
	Fashion Gradient Tint	No charge
	Solid Tint	No charge
	Progressive - available per NVA formulary Standard Premium	$50 Copay – No charge after Copay $85 Copay – No charge after Copay
	Glass Photogrey Single Vision Lens Bi/Tri Lens	$15 Copay – No charge after Copay $25 Copay – No charge after Copay
	Blended Bifocals (Segment)	No charge
	High Index	$55 Copay – No charge after Copay
	Polarized	$60 Copay – No charge after Copay
	Transitions (Standard)	$65 Copay – No charge after Copay
3. FRAME	$100 allowance plus 20% discount on charges over $100 Does not apply for certain proprietary frame brands and where prohibited by law.	
4. CONTACT LENSES (In lieu of eyeglasses)		

a. Contact lens evaluation, fitting and follow up care - Standard (Benefit payable only if Insured chooses contact lenses)	$20 Daily Wear/$30 Extended Wear Copay – No charge after Copay
b. Contact lens evaluation, fitting and follow up care - Specialty (Benefit payable only if Insured chooses contact lenses)	$50 Copay – No charge after Copay
c. Medically Necessary Contact lenses (in lieu of eyeglasses) *Prior authorization required*	No charge
d. Elective Contact lenses (in lieu of eyeglasses)	$100 allowance (plus discount of 15% for Conventional/10% for Disposable off remaining balance over $100 allowance) Does not apply at Contact Fill or Cole corporate locations (if applicable) and where prohibited by law. Prohibited by some manufacturers.

OUT-OF-NETWORK BENEFITS

COVERED SERVICE	$ ALLOWANCE PER COVERED SERVICE	
1. OUT-OF-NETWORK EYE EXAMINATION	$50 allowance	
2. OUT-OF-NETWORK LENSES Standard glass or plastic lenses	Single vision	$35 allowance
	Bifocal	$85 allowance
	Intermediate Vision Lenses	$85 allowance
	Trifocal	$165 allowance
	Lenticular	$165 allowance
3. OUT-OF-NETWORK FRAME	$35 allowance	
4. OUT-OF-NETWORK CONTACT LENSES (In lieu of eyeglasses)		
a. Contact lens evaluation, fitting and follow up care- Standard (Benefit payable only if Insured chooses contact lenses)	Not available	
b. Contact lens evaluation, fitting, and follow up care - Specialty (Benefit payable only if Insured chooses contact lenses)	Not available	
c. Medically Necessary Contact lenses (in lieu of eyeglasses) *Prior authorization required*	$200 allowance	
d. Elective Contact lenses (in lieu of eyeglasses)	$200 allowance	

NOTE: The Insured is responsible for the payment of the additional cost of any extra options the Insured selects other than the Covered Charges shown in this Schedule of Benefits. The Insured shall be responsible for direct payment to the Vision Provider.

DEFINITIONS

The male pronoun includes the female (the term “he” means “he” or “she”).

Active Service: full-time employment at the Insured’s customary place of employment or at a location required by that employment. An authorized absence from work of 3 or more weeks by an insured Employee means that Employee is not in Active Service. An unauthorized absence from work means an individual is not an Employee in Active Service.

Benefit Year: the period beginning on the first date of a Covered Service and ending after the time period specified in the Schedule of Benefits has elapsed. Benefit Year is determined on an individual basis, *i.e.*, each enrolled person (Insured and Dependents) may have a different Benefit Year. The Benefit Year is the 12-month period during which Covered Expenses incurred by the Insured count toward the annual maximum benefit.

Child: an individual:

1. born of the Insured;
2. legally adopted by the Insured;
3. who is a proposed adoptive Child during any waiting period prior to the finalization of the adoption;
4. who is a stepchild of the Insured;
5. who is an unmarried grandchild of the Insured in court-ordered custody of the Insured and who is a Dependent of the Insured; or
6. who is any individual under testamentary or court-appointed guardianship of the Insured, other than temporary guardianship of less than 12 months duration, who is a Dependent of the Insured.

An adopted Child, proposed adoptive Child, and stepchild are treated on the same basis as a natural born Child.

Copay: a fixed copayment amount set in the Schedule of Benefits that is paid by the Insured each time he receives or accesses an in-network Covered Service.

Covered Expense: the covered vision expenses or charges for services shown in the Schedule of Benefits.

*Covered Service***:** Vision Analysis, Vision Survey, lens, frames, and contact lenses paid for or arranged for the Insured by Us under the terms and conditions of the Policy, and described in the Schedule of Benefits.

Dependent: the Insured’s:

1. Spouse/Domestic Partner, if Domestic Partner coverage is offered by the employer and included in the underlying primary major medical coverage;
2. Child from moment of birth to age 26 who is not eligible to enroll in another employer-sponsored vision plan;
3. unmarried Child who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the New York mental hygiene law, or physical handicap, and became so incapable prior to the attainment of the limiting age, and who is chiefly dependent upon the Insured for support and maintenance. Proof of the Child's incapacity and dependency must be submitted to the Company within 31 days after the date the Child’s coverage would normally terminate due to age. At reasonable intervals during the 2 years following that date, the Company may require proof of the Child’s continued incapacity and dependency. After the initial 2 year period, the Company may require proof no more than once a

year.

Insurance coverage for an unmarried Dependent Child who is enrolled as a full-time student remains in effect during school vacations or for a maximum 12-month period during which the Child is on medical leave of absence from school if the Child was insured on the last day of attendance at school.
Dependent coverage is not available to anyone who is a Dependent of more than one covered Employee or who is individually insured under the Policy.

Domestic Partner:

1. an individual who, along with the Insured, has registered in a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. if the individual and Insured reside where registration does not exist, an alternative affidavit of domestic partnership must be provided.
    a. the affidavit must be notarized and must contain the following:
        - the partners are both eighteen years of age or older and are mentally competent to consent to contract.
        - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
        - The partners have been living together on a continuous basis prior to the date of the application.
    b. proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof) must be provided; and
    c. proof that the partners are financially interdependent must be provided. Two or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account
        - A joint credit card or charge card
        - Joint obligation on a loan
        - Status as an authorized signatory on the partner's bank account, credit card or charge card
        - Joint ownership of holdings or investments
        - Joint ownership of residence
        - Joint ownership of real estate other than residence
        - Listing of both partners as tenants on the lease of the shared residence
        - Shared rental payments of residence (need not be shared 50/50)
        - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
        - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
        - Shared household budget for purposes of receiving government benefits
        - Status of one as representative payee for the other's government benefits
        - Joint ownership of major items of personal property (e.g., appliances, furniture)
        - Joint ownership of a motor vehicle
        - Joint responsibility for child care (e.g., school documents, guardianship)
        - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
        - Execution of wills naming each other as executor and/or beneficiary
        - Designation as beneficiary under the other's life insurance policy
        - Designation as beneficiary under the other's retirement benefits account
        - Mutual grant of durable power of attorney

- Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
- Affidavit by creditor or other individual able to testify to partners' financial interdependence
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

Eligible Status: the class to which an Employee belongs. Each new Employee in an insured class must be added to the appropriate class.

Employee: an individual who works for the Policyholder. A full-time Employee works at least 20 hours per week.

Immediate Family: the Insured's Spouse; natural and adoptive parents, Children and siblings; stepparents, stepchildren and step-siblings; fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, sons-in-law and daughters-in-law; and grandparents and grandchildren. Immediate Family member also includes, for purposes of this Certificate, a Domestic Partner and the dependent(s) of a Domestic Partner.

Insured: the Employee who has enrolled for coverage under the Policy and is issued a Certificate. Insured includes eligible Retirees of the Policyholder and eligible Dependents when coverage for these individuals is provided.

Medically Necessary: health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Non-Participating Provider: a Vision Provider who is not a member of the Provider Network. Treatment by a Non-Participating Provider is out-of-network treatment.

Ophthalmologist: a person licensed as a medical doctor who specializes in diseases and refractive errors of the eye.

Optician: a person licensed to read prescriptions for visual correction, order lenses, and dispense eyeglasses and contact lenses.

Optometrist: a person licensed and specializing in the examination of the eyes and related structures to determine the presence of vision problems and eye disorders who prescribes adaptive lenses and other optical aids.

Participating Provider: a Vision Provider who is a member of the Provider Network. In general, treatment by a Participating Provider is considered in-network treatment.

Policy Year: The one-year period from the Policy Effective Date to the last day of the month immediately prior to the Effective Date; or any part of that period during which the Policy was in force.

Provider Directory: a list of Vision Providers who are part of the Provider Network. The Provider Directory is updated periodically.

Provider Network: the group of participating Vision Providers who have agreed to accept a schedule of maximum fees as payment in full for services rendered.

Retiree: a former full-time Employee of the Policyholder who was covered by insurance provided by the Policyholder while a full-time Employee of the Policyholder who is no longer employed in any capacity.

Roster: a policy that is issued requiring detailed census information from the Policyholder.

Spouse: the person of same or different sex the Insured is legally married to in New York or another jurisdiction. The Company does not consider a person a Spouse if the Insured is divorced from that person, or the marriage has been annulled.

Vision Analysis: a complete evaluation of the Insured performed by a licensed Ophthalmologist or Optometrist when the Insured has visual symptoms, or when the Vision Survey indicates the need for such an examination; the Vision Analysis includes prescribing glasses when indicated.

Vision Provider: a treating vision practitioner, who is licensed as an Optician, an Optometrist or an Ophthalmologist, and acting within the scope of his license.

1. A vision practitioner must be licensed to provide vision services under the laws of the state where the services are rendered.
2. A physician assistant (PA) to a Vision Provider must be licensed to practice specified vision services and must work under the supervision of a Vision Provider under the laws of the state where the services are rendered.

Vision Survey: a routine eye examination performed by a licensed Optometrist or Ophthalmologist on a regular basis, including a survey of principal visual functions.

You: the Insured.

ELIGIBILITY, WAITING PERIOD AND EFFECTIVE DATE

Coverage under this Certificate is provided only to individuals who are in one or more of the following categories.

Employees In Active Service on the Policy Effective Date who:

1. Are members of an eligible class as shown on the master application; and
2. Have completed 1 month of employment; and
3. Are currently employed with the Policyholder on a full-time basis; and
4. Are over the age of 18; and
5. Are Dependents of those eligible Employees, if Dependent coverage is provided; will be covered under the Policy, if a completed enrollment form is submitted to the Company by or on behalf of the eligible Employee(s) within 30 days of the Effective Date of the Policy.

The Company will not cover the Employee or any Dependents until the Employee enrolls.

Employees Not In Active Service on the Effective Date of the Policy due to disability or other medical condition, but who are otherwise members of a covered class, will be covered under the Policy on the date the Employee returns to work full-time. A completed enrollment form must be submitted to the Company by the first day of the month immediately following the return to Active Service. Premium payment(s) must be made as of the proper effective date(s).

Employees who are new hires during the Policy period and who are members of a covered class will be covered under the Policy on the first day of the calendar month following the Employee's date of hire. A completed enrollment form must be submitted to the Company by the first day of the month immediately following the first date of hire or employment. Premium payment(s) must be made as of the proper effective date(s).

Employees who are late enrollees (any Insured or Dependent who does not enroll within the first 30 days after he is eligible for coverage or whose coverage has lapsed due to a failure to make required premium payments) will be covered after notification of eligibility and payment is made. If notification of eligibility is made after 30 days, coverage will begin on the next premium due date and will be limited to a Vision Eye Examination for 6 calendar months following the Effective Date of coverage. Thereafter, full benefits under the Policy will be available.

Retirees on the Policy Effective Date who:

1. Are former full-time Employees of the Policyholder who were covered by vision insurance provided by the Policyholder while a full-time Employee of the Policyholder; and
2. Are no longer employed in any capacity; or
3. Are covered Employees on the Policy inception date who retire during the Policy term; and Dependents of those eligible Retirees, if Dependent coverage is provided, will be covered under the Policy, if a completed enrollment form is submitted to the Company by or on behalf of the eligible Retiree(s) within 30 days of the retirement date.

The Company will not cover the Retiree or any Dependents of the Retiree until the Retiree enrolls.

Spouse/Domestic Partner or Dependent Child(ren) Coverage: if Dependent coverage is offered, an Insured may elect to cover himself and a Spouse/Domestic Partner or any Children under the Policy by signing an enrollment form listing those Dependents. In the event that Dependents may be considered Dependents of more than one eligible Insured, benefits for such Dependents may be carried by only one Insured.

1. The effective date of coverage for each Spouse/Domestic Partner or Dependent

Child will be the first day of the month in which:

a. the Insured becomes eligible for Spouse/Domestic Partner or Dependent Child coverage, if he signs a proper enrollment form on or within 30 days of the date of eligibility; or
b. if the Insured signs an enrollment form more than 30 days after the date he becomes eligible for Spouse/Domestic Partner or Dependent Child coverage, the date on which the enrollment form is submitted to the Company.

2. If an Insured marries, or enters into a domestic partnership, or has a Dependent Child after the effective date of his coverage, Dependent coverage will begin immediately, if the proper premium is timely paid. If the Insured's Spouse/Domestic Partner has died, Dependent Children covered by the deceased's Certificate may be added to this Certificate at any time within 6 months of the death of the Spouse/Domestic Partner.
3. If an Insured's Spouse/Domestic Partner is involuntarily terminated from employment for any reason other than cause, the Spouse/Domestic Partner and Dependent Children may be added to this Certificate at any time within 6 months after coverage terminated under the Spouse/Domestic Partner's insurance Certificate.
4. Coverage for a newborn Dependent Child begins at the moment of birth. Newly adopted Children, stepchildren, and proposed adoptive Children are eligible for coverage on the same basis as natural Children. Coverage for a grandchild or other minor for whom testamentary or court-appointed guardianship is granted begins on the date of appointment.

TERMINATION OF COVERAGE

Grace Period: This Certificate has a grace period of 30 days following each premium due date within which to pay all overdue premium. During the grace period, the Certificate will remain in force.

Policy Termination: Cancellation will be effective only if written notice is provided by either the Company or the Policyholder at least 30 days prior to the cancellation date. Notice will be sent to the master Policyholder at the last address shown in the Company records.
The Policy will be cancelled at the end of the grace period, retroactive to the last premium due date, if the premium is not paid by the end of the grace period.

Individual Terminations: Coverage of an Insured will end when any one of the following occurs:

1. The entire Policy is terminated;
2. The Insured ceases to be eligible for coverage under the Policy;
3. The Policyholder fails to pay the premium due by the end of the grace period, if the Policyholder pays the premium;
4. The premium is unpaid for any reason at the end of the grace period; or
5. The Insured fails to make any contribution, if contribution is required under the plan.

Dependent coverage ceases upon the earlier of the termination of the Insured's coverage, the date the Dependent ceases to be eligible for coverage under this Certificate, or the Dependent qualifies to be insured as an individual under the Policy.

If an Insured is totally disabled on the date the Policy terminates for any reason, coverage will remain in effect for that Insured for Covered Charges incurred within 90 days after the termination date. If an Employee covered under the Policy dies, coverage for his Dependents will continue for 180 days after the date of death.

Termination of the Policy will not affect a claim that occurred while insurance was in force under the Policy.

EXCLUSIONS

No benefits are payable except as stated in the Policy and this Certificate.

This insurance does not apply to any expense for which:

1. Services are performed by a member of the covered person's Immediate Family;
2. Benefits are provided under Medicare or other governmental program (except Medicaid), employers' liability or occupational disease law;
3. Benefits are provided under any state or Federal workers' compensation law;
4. Service no charge is normally made;
5. Illness, accident, treatment, or medical condition arises out of intentionally self-inflicted injury; or
6. Illness, accident, treatment, or medical condition arises out of war or act of war, declared or not, or participation in a felony, riot, or insurrection.

COORDINATION OF BENEFITS

This section applies when You also have group vision coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for vision care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group vision coverage with which We will coordinate benefits. The term "plan" includes:
   - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
   - Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
   - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Insured and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a Child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are

considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a Child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the Child's health care expenses:
    - The plan of the parent who has custody will be primary;
    - If the parent with custody has remarried, and the Child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
    - If a court decree between the parents says which parent is responsible for the Child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active Employee or member (i.e., not laid-off or retired), or as the Spouse or Child of such an active Employee, and is also covered under another plan as a laid-off or retired Employee or as the Spouse or Child of such a laid-off or retired Employee, the plan that covers such person as an active Employee or Spouse or Child of an active Employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

STANDARD PROVISIONS

Claim Forms: The Company will send the Insured claim forms when it receives written notice of claim. The notice should include the Insured's name, address, the Policyholder's name, and the Policy number. If claim forms are not furnished by the Company within 15 days after the Company has received written notice of claim, the Insured will be deemed to have complied with the requirement by submitting any written documents to the Company in order to prove the claim. Claim forms may also be downloaded from the ShelterPoint Life website at: www.shelterpoint.com.

Legal Actions: No legal action may be brought by an Insured under this Certificate within 60 days after written proof of loss has been sent to the Company as required by this Certificate so that the Company may have sufficient time to make a determination on the claim. No legal action may be brought by an Insured under this Certificate after the expiration of 2 years following the time such proof of loss is required by the Certificate.

Notice of Claim: The Insured must give written notice of any claim to the Company within 20 days of the date of the occurrence of any loss. If it is impossible to do so, the Company must be notified of any claim in writing as soon as is reasonably possible. Failure to give notice within 20 days will not invalidate or reduce a claim provided notice is given as soon as reasonably possible.

Physical Examination and Autopsy: The Company, at its own expense, shall have the right and opportunity to examine the person of any individual whose loss is the basis of claim under this Certificate when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Proof of Loss: Written proof of loss must be sent to the Company within 120 days after the date of loss. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Payment of Claims: If the Insured dies, any benefits due and unpaid at the time of death will be paid to the Insured's beneficiary or in the absence of a designated beneficiary, to the estate of the Insured. All other benefits will be paid to the Insured. The Insured may request the Company to pay vision benefits directly to the provider of the vision service. Assignment of benefits under this Certificate is permitted.
Any payments made in good faith will end the Company's liability to the extent of the payment.

Timely Payment of Claims: When the Company receives written proof of loss and all required supporting documentation, any benefits due will be paid within 60 days. However no benefits will be paid for claims incurred during any grace period for premium payment, until all outstanding premium payments have been made.

Internal Appeal of Claim: The Insured must notify the Company of any appeals, in writing, within 180 days of the date of the claim decision. If it is impossible to do so, the Company must be notified of any appeal in writing as soon as is reasonably possible. The Company will assign the appeal to be reviewed within 30 days by an internal examiner. Notification of the outcome would be made in the same manner as for all other claims.

SHELTERPOINT

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New York State

Policyholder Protection

Provided by the Life Insurance Company Guaranty Corporation of New York

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ANDREW M. CUOMO
Governor

BENJAMIN M. LAWSKY
Superintendent of Financial Services

Overview

This brochure summarizes protections provided by the Life Insurance Company Guaranty Corporation of New York (LICGC) to New York policyholders in the event of the financial insolvency of any New York-licensed life insurance company owing benefits under outstanding life insurance policies, annuity contracts or accident and health insurance policies.
The brochure responds to some of the most frequently asked questions concerning the LICGC and should not be considered a legal opinion of either the New York State Department of Financial Services or the Life Insurance Company Guaranty Corporation of New York.

If you have questions after reviewing the brochure, you may write to the LICGC in care of the New York State Department of Financial Services' Life Insurance Bureau, One State Street, New York, NY 10004.

The LICGC is a not-for-profit New York corporation created under a special statute enacted in 1985, *The Life Insurance Company Guaranty Corporation of New York Act.* Every life insurance company licensed to do business in the State of New York must be a member of the LICGC as a condition of transacting an insurance business in the State. A Board of Directors, consisting of representatives of member insurers and the Superintendent of Financial Services manages the operations of the LICGC.

One of the Department of Financial Services' most important responsibilities is regulating the activities of life insurers doing business in the State to ensure that the promises made in

insurance policies are fulfilled. Therefore, each life insurer licensed in New York submits comprehensive annual and quarterly reports on its financial condition.

In addition, the Department's insurance examiners conduct regular on-site examinations of all **domestic life insurers** (those insurers incorporated in New York) to evaluate their financial condition, as well as their underwriting and claims-handling practices. Out-of-state life insurers doing business in New York are subject to on-site examinations by their home state insurance departments.

The Department's record in regard to life insurer solvency is an excellent one. With the creation of the Life Insurance Guaranty Corporation in 1941, New York became the first state in the country to provide consumers with a measure of protection against life insurer insolvency. Since those original guaranty fund protections were established, the fund has been needed only three times to pay policyholder claims.

Q: How does the LICGC work?

A: The LICGC is required by law to provide funds to protect **New York resident policyholders** in the event of the insolvency of a **licensed life insurer**.

The LICGC is funded through assessments against member insurers made after a member insurer is declared insolvent by a court of law. Such funds are used to pay valid claims as well as administrative expenses.

In addition, insurance policies and annuity contracts issued by **domestic life insurers** prior to August 2, 1985 may also have protection provided by a separate fund, administered by the Life Insurance Guaranty Corporation, which was established before the LICGC was created in 1985.

Q: What types of insurance policies are protected by the LICGC?

A: The LICGC protects life insurance policies as well as annuity contracts and accident and health insurance policies issued by licensed life insurers, subject to certain limitations. Limited protection is also available for other types of contracts as discussed below.

Q: Are there any limits on the protection afforded by the LICGC?

A: The LICGC will provide up to $500,000 of coverage to a life insurance policyholder/beneficiary, an individual annuity (such as a Single Premium Deferred Annuity) contract holder or an **individual** accident and health insurance policyholder. In addition, the full benefits of **group** accident and health insurance policies issued by licensed life insurers are protected for a minimum of six months.

Also, limited coverage is afforded to funding agreements and group annuity contracts. Both group annuity contracts, including guaranteed interest contracts, and funding agreements, are frequently used for the investment of the assets of pension, profit-sharing and salary reduction type plans. Most often it is the plan trustee or sponsor who makes the investment. The extent of

LICGC protection for an individual participant depends on the insurer's obligation as set forth in the contract.

If the contract does not guarantee annuity benefits with respect to any specific individual identified in the contract, the LICGC will provide coverage for the total invested with the insurer, up to $1 million. However, if the contract does guarantee annuity benefits with respect to specific individuals identified in the contract, then the LICGC will provide up to $500,000 of coverage to such individuals who are New York residents.

With respect to funding agreements that do not fund benefits under employee benefit plans, the LICGC provides aggregate coverage of up to $500,000. For more specific information about the type of contract through which your protection is provided, you should contact your employer's personnel office.

Q: My insurance company's home office is in another state, but the company is licensed in New York. Am I protected by the LICGC?

A: You are protected if you were a resident of New York State when you purchased the policy or are a resident at the time your insurance company becomes insolvent. Policies purchased from domestic life insurers prior to August 2, 1985 may have additional protection through the separate Life Insurance Guaranty Corporation, regardless of residency.

Q: I bought my life insurance policy when I lived in New York but now I live in Florida. Am I protected?

A: As long as you were a resident of this State at the time of purchase and your insurer was licensed here, you are protected. You may also have protection in your current state of residence.

Q: I have a separate account variable annuity contract, i.e., my funds are invested separately from those of the company and I bear all the risk of gains and losses. What kind of protection do I have?

A: The LICGC provides no protection under the contract described above. As noted, you bear the entire risk under the contract. However, there are some separate accounts in which individuals do not bear the full amount of the risk and some protection would be available for these kinds of contracts. Assets in such separate accounts would normally retain their separate status in the event of the insolvency of the issuing insurer and could not be used to pay that insurer's other debts and obligations that do not arise out of the business of the separate account.

Q: My separate account annuity guarantees a minimum return. Am I protected by the LICGC?

A: You are protected, but only for the portion of the contract that is guaranteed. Presumably, most of this guaranteed amount would be payable from the assets of the separate account. The LICGC would come into play only in the event of a shortfall as to the guaranteed amount.

Q: I have a 401(k) plan with my employer. I have selected a fixed interest option funded by a guaranteed investment contract (GIC) issued by a life insurance company to my employer. Will my invested funds be protected?

A: A 401(k) plan is a retirement savings plan in which employees contribute through payroll deductions to a fund to be used for retirement. If the guaranteed interest contract guarantees annuity benefits with respect to specific individuals identified in the contract, then such individual is protected by the LICGC up to a maximum of $500,000.

However, if the guaranteed interest contract does not guarantee annuity benefits with respect to any specific individual identified in the contract, the contract is protected up to a maximum of $1 million in the aggregate for all claims made under that contract.

Q: My husband and I each have an annuity contract worth $300,000. Does the $500,000 cap apply to us jointly?

A: No, the LICGC puts the aggregate limit of $500,000 on any one life. Therefore, the limit would apply to you and your husband separately.

Q: How can I find out if my insurer is licensed in New York State?

A: The Department of Financial Services maintains a list of all companies currently licensed in New York State. The list is located on the Department's Web site, **www.dfs.ny.gov** — select "Insurance Industry" to locate the link for the "Insurance Company Search" application.

Q: What happens when an insurance company experiences financial difficulty?

A: The Insurance Law provides that the Superintendent may seek an order from the New York State Supreme Court to allow him or her to take over a domestic insurer's operations if any of a variety of circumstances exist, including situations that affect a company's financial stability.

This supervision of a company may take either of two forms: rehabilitation or liquidation. The essential difference is that under rehabilitation, the Superintendent attempts to return the company to a financially stable condition, whereas under liquidation, steps are taken toward the eventual dissolution of the company. Both are designed to enable the Superintendent to protect the insurer's policyholders and other creditors.

If a company is domiciled in another state that has placed it in rehabilitation or liquidation, the Superintendent may seek a court order allowing him or her to take control of the company's assets in New York. The LICGC is available to pay policyholder claims after a court declares any licensed insurer insolvent. This declaration is typically found in a court order of rehabilitation or liquidation.

Q: Will I have to wait for payments once my insurer is taken over by the Superintendent?

A: When your insurer is initially taken over by the Superintendent, payments to you from your insurer may be suspended. Delays could be necessary to allow the Superintendent time to sort out the affairs of the financially troubled insurer. As a result, in some cases, you may have to wait many months before receiving payments; in other cases, benefits may not be delayed at all.

Q: Does the LICGC have enough money to pay policyholder benefits?

A: The LICGC obtains money to continue coverage and pay eligible claims by making assessments of the LICGC's other member insurance companies. Under current law, the LICGC's total amount of outstanding assessments is limited to $558 million. The LICGC expects that a pending insolvency will consume the corporation's remaining assessment capacity. Accordingly, efforts are currently underway to examine alternatives that would result in the LICGC being able to meet its payment obligations with respect to any insolvencies that may arise in the future. The life insurance industry in New York is committed to working with relevant parties in the state government to develop a solution that meets this objective.

Q: How will I know if my insurer is taken over by the Superintendent?

A: Once the Superintendent of Financial Services steps in to take over an insurer, official notice is sent to all policyholders explaining the circumstances that made the action necessary. In addition, notices are published in the newspapers.

The Life Insurance Company Guaranty Corporation was created to provide protection for New York life insurance policyholders in the event of insurer insolvency. However, the best protection for consumers is care in selecting an insurer and a policy.

ShelterPoint Life Insurance Company
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www.shelterpoint.com | Phone: 800.365.4999 (516.829.8100)

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

ShelterPoint Life Insurance Company (ShelterPoint Life) maintains confidential policyholder and individual insured files. In compliance with state and federal law, protected health information may be collected and/or released to assist ShelterPoint Life in underwriting or claims processing activities or pursuant to an order from a court of competent jurisdiction.

Insureds may access personal information (except when access is prohibited by law) by contacting:

Customer Service
ShelterPoint Life Insurance Company
600 Northern Boulevard
Great Neck, New York 11021

Telephone: (516) 829-8100
(800) 365-4999
Fax: (516) 504-6412
E-mail: customerservice@shelterpoint.com

If there is a change in your personal information, you should notify ShelterPoint Life Customer Services. ShelterPoint Life may amend its privacy poli cy and/or our notice as necessary. You may obtain a copy of ShelterPoint Life's current privacy policy by contacting ShelterPoint Life Privacy Officer in the Legal Department.

SHELTERPOINT LIFE'S POLICIES AND PRACTICES PROTECT YOUR PERSONAL INFORMATION

In general, ShelterPoint Life does not release any protected health information or other confidential information unless you provide a signed release authorization valid for two years. Protected health information (PHI) is individually identifiable health information related to your physical or mental health or condition, health care services provided to you or payments made for your care. PHI may be released to a plan sponsor or policyholder for policy administration purposes without a signed authorization . PHI may be released to a treating physician or to permit ShelterPoint Life to process a claim. PHI may be exchanged with third parties responsible for payment of related charges.

PERSONAL HEALTH INFORMATION: ShelterPoint Life collects and uses personal information in connection with underwriting functions, policy application review, policy administration and claims processing. Where permitted by law, ShelterPoint Life collects information from licensed insurance brokers and agents in connection with the sale of its products. Information may be exchanged with your medical provider to permit ShelterPoint Life to process your claim. Information may be provided to your plan administrator to assist it in seeking policy amendments, modifications or improvements or to permit it to process claim requests.

INFORMATION SECURITY: ShelterPoint Life **does not release** any information about any insured or claimant without a current authorization signed by the insured, except as permitted by law. ShelterPoint Life maintains all policyholder and insured records in confidential, secure locations.