

YOUR BENEFIT PLAN

NUTANIX, INC.

Questions or Complaints about Your Coverage

In the event You have questions or complaints regarding any aspect of Your coverage, You should contact Your Benefits department.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

**The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233**

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **For Your Questions and Complaints:**
Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Toll Free: 1(800) 852-5494
Local: 1(501) 371-2640

California:

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

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

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

- 1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or

others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;

- 2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
- 3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
- 4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

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

2. For Your Questions and Complaints:

State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833

Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.
2. **NOTICE:** The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.

Georgia:

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

Idaho:

1. For Your Questions and Complaints:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

Illinois:

1. For Your Questions and Complaints:

Illinois Department of Insurance

Consumer Services Station
Springfield, Illinois 62767
Consumer Assistance: 1(866) 445-5364

Officer of Consumer Health Insurance: 1(877) 527-9431

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

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

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

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

Indiana:

1. **For Your Questions and Complaints:**
Public Information/Market Conduct
Indiana Department of Insurance
311 W. Washington St. Suite 300
Indianapolis, IN 46204-2787
1(317) 232-2395

Louisiana:

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

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

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

The reinstated coverage will:

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

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

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

Maryland:

1. **NOTICE:** The group insurance Policy providing coverage under the Certificate may have been issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE:** As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the **Minimum Creditable Coverage** standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

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

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

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions**.
2. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:

- 1) the date Your coverage would otherwise terminate; or
 - 2) the date You receive a written notice of Your right to continue coverage from the Employer;
- whichever is later.

The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:

- 1) Your right to continue coverage;
- 2) the amount of premium; and
- 3) how, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:

- 1) the date You are covered under another group policy;
- 2) the date the required premium is due but not paid; or
- 3) the last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:

- 1) exercise Your Conversion Right; or
- 2) continue coverage under a group Portability policy; and
- 3) qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit

4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

Missouri:

1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:

1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate

New Hampshire:

1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

Spouse Continuation: *Can coverage for my Spouse be continued in the event of divorce or separation?*

If:

- 1) You are a resident of New Hampshire;
- 2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
- 3) the final decree of divorce or legal separation does not expressly prohibit it;

Your former Spouse may continue his or her coverage.

We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

- 1) the 3-year anniversary of the final decree of divorce or legal separation;
- 2) the remarriage of the former Spouse;
- 3) Your death;
- 4) an earlier time as provided by the final decree of divorce or legal separation; or
- 5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

New York:

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
 - 1) you are both are legally and mentally competent to consent to contract in the state in

- which you reside;
- 2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
 - 3) you have been living together on a continuous basis prior to the date of the application;
 - 4) neither of you have been registered as a member of another domestic partnership within the last six months; and
 - 5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

- 1) a joint bank account;
- 2) a joint credit card or charge card;
- 3) joint obligation on a loan;
- 4) status as an authorized signatory on the partner's bank account, credit card or charge card;
- 5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
- 6) listing of both partners as tenants on the lease of the shared residence;
- 7) shared rental payments of residence (need not be shared 50/50)
- 8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- 9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
- 10) shared household budget for purposes of receiving government benefits;
- 11) status of one as representative payee for the other's government benefits;
- 12) joint responsibility for child care (e.g., school documents, guardianship);
- 13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
- 14) execution of wills naming each other as executor and/or beneficiary;
- 15) designation as beneficiary under the other's life insurance policy;
- 16) designation as beneficiary under the other's retirement benefits account;
- 17) mutual grant of durable power of attorney;
- 18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- 19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
- 20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
 - 1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
 - 2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

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

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to \$2,000, if greater than \$2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

2. IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-523-2233

You may also write to The Hartford at:

P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de The Hartford's para obtener información o para presentar una queja al:

1-800-523-2233

Usted también puede escribir a The Hartford:

P.O. Box 2999
Hartford, CT 06104-2999

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Utah:

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

Vermont:

1. The following requirement applies:

Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a

civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

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

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

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1. **For Your Questions and Complaints:**

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1(804) 371-9741 (inside Virginia)
1(800) 552-7945 (outside Virginia)

Washington:

1. The following **Disputed Diagnosis** requirement applies to You:

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

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

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

Wisconsin:

1. For Your Questions and Complaints:

To request a Complaint Form:

Office of the Commissioner of Insurance

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

1(800) 236-8517 (outside of Madison)

1(608) 266-0103 (in Madison)



HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: NUTANIX, INC.
Policy Number: GL-877221
Policy Effective Date: January 1, 2016
Policy Anniversary Date: January, 2017

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Lisa Levin, Secretary

Michael Concannon, President

YOUR RIGHT TO RETURN THE CERTIFICATE: YOU HAVE THE RIGHT TO RETURN THE CERTIFICATE WITHIN 30 DAYS AFTER ITS RECEIPT VIA REGULAR MAIL OR OTHER DELIVERY METHOD AND TO HAVE THE FULL PREMIUM AND MEMBERSHIP FEES REFUNDED. THE RETURN VOIDS THE CERTIFICATE FROM THE BEGINNING. THE PARTIES SHALL BE IN THE SAME POSITION AS IF NO CONTRACT HAD BEEN ISSUED. ALL PREMIUMS PAID AND ANY POLICY FEE SHALL BE FULLY REFUNDED BY US, AND ANY MEMBERSHIP FEE SHALL BE FULLY REFUNDED BY THE ENTITY CHARGING THE FEE, WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE.

A note on capitalization in this Certificate:

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

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SCHEDULE OF INSURANCE

Cost of Coverage:

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

Eligible Class(es) For Coverage: All Full-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees.

Full-time Employment: at least 30 hours weekly

Life Insurance Benefit

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

3 times Your annual Earnings, subject to a maximum of \$1,000,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Basic Amount of Life Insurance be less than \$10,000.

Accidental Death and Dismemberment Benefit

Basic Principal Sum

Maximum Amount

3 times Your annual Earnings, subject to a maximum of \$1,000,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Basic Principal Sum be less than \$10,000.

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You by any Amount of Life Insurance in force, paid or payable:

- 1) in accordance with the Conversion Right;
- 2) under the Portability provision; or
- 3) under the Prior Policy.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit and Principal Sum for You by the percentage indicated in the table below. This reduction will be effective on the Policy Anniversary Date following the date You attain the ages shown below. The reduction will apply to the Amount of Life Insurance and Principal Sum in force immediately prior to the first reduction made.

Reductions also apply if:

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

on or after the date You attain age 70.

| Percentage by which original amount of coverage will be reduced. | Your Age | Your % Reduction |
|--|----------|------------------|
| | 70 | 35% |

The reduced amount of coverage will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. An appropriate adjustment in premium will be made.

Additional Accidental Death and Dismemberment Benefits

Seat Belt Benefit Amount

Percentage of Accidental Death and Dismemberment Principal Sum: 10%
 Maximum Amount: \$25,000
 Minimum Amount: \$1,000

Air Bag Benefit Amount

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

Repatriation Benefit

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

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*

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

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

You will become eligible for coverage on the latest of:

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

Enrollment: *How do I enroll for coverage?*

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

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Coverage will start on the date You become eligible.

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

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

If, on the date You are to become covered:

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

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

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*

Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date, You were not Actively at Work, and would

otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance and accidental death and dismemberment principal sum:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after the Policy Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- 4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
- 3) the date the premium payment is due but not paid;
- 4) the date Your Employer terminates Your employment; or
- 5) the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

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

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

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

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

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

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

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

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage may be continued for up to 26 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

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

Status Change: If You are:

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

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

Disability Insurance: If You are working for the Policyholder and:

- 1) are covered by; and
- 2) meet the definition of disabled under;

a group long term disability insurance policy, issued by Us to Your Employer, Your coverage may be continued for a period of 12 consecutive month(s) from the date You were last Actively at Work while You remain disabled.

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

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

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

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

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

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

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

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

This provision applies only to:

- 1) Your Basic Life Insurance;
- 2) Your Supplemental Life Insurance; and
- 3) Dependent Life Insurance.

You are not eligible to apply for both the Portability Benefit and Waiver of Premium for the same coverage amount for You.

Disabled: *What does Disabled mean?*

Disabled means as a result of injury or sickness, You are unable to engage with reasonable continuity in Your own occupation for 24 months after the date of disability. Beyond the initial 24 month period, You are considered Disabled if, due to the same injury or sickness, You are unable to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life, and physical and mental capacity.

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

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

To qualify for Waiver of Premium You must:

- 1) be covered under The Policy and be under age 65 when you become Disabled;
- 2) be Disabled and provide Proof of Loss that You have been Disabled for 9 consecutive months, starting on the date You were last Actively at Work or provide proof that You have been diagnosed with a life expectancy of 12 months or less; and
- 3) provide such proof within one year of Your last day of work as an Active Employee.

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

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

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

- 1) require Proof of Loss that You are Disabled; and

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

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

However, if We deny Waiver of Premium, You may be eligible to:

- 1) continue coverage under the Portability Benefit; or
- 2) convert coverage in accordance with the Conversion Right.

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

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

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

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

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

We will waive premium payments and continue Your coverage, while You remain Disabled, until You attain age 65, if You became Disabled on or after age 60.

What happens when Waiver of Premium ceases?

When the Waiver of Premium ceases:

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

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

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

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

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

BENEFITS

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

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

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

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

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

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

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

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

Loss means with regard to:

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

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

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

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

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

This Benefit will be paid:

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

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

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

The Seat Belt Benefit is the lesser of:

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

The Air Bag Benefit is the lesser of:

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

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

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

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

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

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

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

Intoxicated means:

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

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

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

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

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

This Benefit will be paid:

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

The Repatriation Benefit will pay the least of:

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

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

Accelerated Benefit: *What is the benefit?*

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

- 1) covered under The Policy for an Amount of Life Insurance of at least \$10,000; and
- 2) under age 65;

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

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

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

The Amount of Life Insurance payable upon Your death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required will be based on the amount of Your life insurance remaining after the Accelerated Benefit is paid under this benefit. There will be no effect on the Accidental Death and Dismemberment Benefit Principal Sum after the Accelerated Benefit Amount is paid under this benefit.

You may request a minimum Accelerated Benefit amount of \$3,000, and a maximum of \$500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of Your Amount of Life Insurance. This option may be exercised only once.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of \$100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from \$3,000 to \$80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only \$3,000 now, You cannot request the additional \$77,000 in the future.

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

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

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

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

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

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

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

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

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

If Life Insurance coverage or any portion of it under The Policy ends for any reason, You have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

- 1) the Accidental Death and Dismemberment Benefits; or
- 2) any Amount of Life Insurance for which You were not eligible and covered;

under The Policy.

If coverage under The Policy ends because:

- 1) The Policy is terminated; or,
- 2) coverage for an Eligible Class is terminated;

then You must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- 1) \$10,000; or
- 2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

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

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

Conversion: *How do I convert my coverage?*

To convert Your coverage You must:

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

The Insurer must receive this within:

- 1) 31 days after Life Insurance terminates; or
- 2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

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

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

within the time period specified in the proposal.

Any individual policy issued to You under the Conversion Right:

- 1) will be effective as of the 32nd day after the date coverage ends; and
- 2) will be in lieu of coverage for this amount under The Policy.

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

The Conversion Policy will:

- 1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
- 2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as The Policy;
- 2) any benefit other than the Life Insurance Benefit; and
- 3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:

- 1) in accordance with the Waiver of Premium provision;
- 2) under a certificate of insurance issued in accordance with the Portability provision; or
- 3) in accordance with the Continuation Provisions;

until such coverage ends.

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

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

- 1) coverage under The Policy terminates; and
- 2) You die within 31 days of the date coverage terminates; and
- 3) We receive Proof of Loss.

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

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

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

Portability Benefits: *What is Portability?*

Portability is a provision which allows You to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events. Portability applies to Basic Life Insurance coverage only.

Qualifying Events: *What are Qualifying Events?*

Qualifying Events for You are:

- 1) Your employment terminates for any reason prior to Normal Retirement Age; or
- 2) Your membership in an Eligible Class under The Policy ends; provided the Qualifying Event occurs prior to Normal Retirement Age.

Electing Portability: *How do I elect Portability?*

You may elect Portability for Your coverage after Your Basic Life Insurance coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available.

To elect Portability for yourself, You must:

- 1) complete and have Your Employer sign a Portability application; and
- 2) submit the application to Us, with the required premium.

This must be received within:

1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the application;
whichever is later. However, Portability requests will not be accepted if they are received more than 91 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

- 1) issued without Evidence of Insurability;
- 2) issued on one of the forms then being issued by Us for Portability purposes; and
- 3) effective on the day following the date Your coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

Limitations: *What limitations apply to this benefit?*

You may elect to continue 50%, 75%, or 100% of the Amount of Life Insurance which is ending for You. This amount will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. However, the Amount of Life Insurance that may be continued will not exceed \$250,000 for You.

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You be able to continue an Amount of Life Insurance which is less than \$5,000.

Portability is not available for any Amount of Life Insurance for which You were not eligible and covered.

In addition Portability is not available if You are entering active military service.

Effect of Portability on Other Provisions: *How does Portability affect other Provisions?*

Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

- 1) Conversion Right;
- 2) Waiver of Premium provision; or
- 3) Continuation provisions;

under The Policy. However, if:

- 1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or
- 2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

The Waiver of Premium provision will not be available if You elect to continue coverage under this Portability Benefit.

EXCLUSIONS

Exclusions: *What is not covered under The Policy?*

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

- 1) intentionally self-inflicted Injury;
- 2) suicide or attempted suicide, whether sane or insane;
- 3) war or act of war, whether declared or not;
- 4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- 5) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- 6) Injury sustained while committing or attempting to commit a felony; or
- 7) Injury sustained while Intoxicated.

Intoxicated means:

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

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

GENERAL PROVISIONS

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

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by The Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at Lexington, KY, with information sufficient to identify the insured active insured person, shall be deemed notice to Us.

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

We, upon receipt of a notice of claim, will furnish to You such forms as are usually furnished by Us for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice, You shall be deemed to have complied with the requirements of The Policy as to Proof of Loss upon submitting, within the time fixed in The Policy for filing Proof of Loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

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

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

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

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

Written Proof of Loss should be sent to Us or Our representative:

- 1) with respect to the Life Insurance Benefits within 365 day(s); and
- 2) with respect to the Accidental Death and Dismemberment Benefits within 90 day(s);

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

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

- 1) it was not reasonably possible to give proof within the required time; and
- 2) proof is given as soon as reasonably possible; but
- 3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

For Accelerated Benefit, Written Proof of Loss must be furnished to Us, in case of claim for loss for which The Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claim: *When are benefit payments issued?*

Indemnities payable under The Policy for any loss other than loss for which The Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written Proof of Loss, all accrued indemnity for loss for which The Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

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

We at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*

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

Benefits may be subject to interest payments as required by applicable law.

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

Life Insurance Benefits and benefits for loss of life under the Accidental Death and Dismemberment Benefit will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

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

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

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

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

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

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

If benefits are payable and meet Our guidelines, then You, or your Beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:

- 1) You, if living; or
- 2) Your beneficiary, in the event of Your death.

However, an account will not be established for:

- 1) a benefit payable to Your estate; or
- 2) an amount that is less than \$10,000.

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

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

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

For Accelerated Benefit, all payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any indemnity of The Policy shall be payable to the estate of the insured employee, or to an insured employee or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding \$1,000 to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Change of Beneficiary: *Who has the right to change the beneficiary?*

The right to change of beneficiary is reserved to the insured employee, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

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

In no event may a beneficiary be changed by a power of attorney.

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

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

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

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

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

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

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

Eligibility Determination: *How will We determine Your eligibility for benefits?*

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

- 1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;
- 2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
- 3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries' claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
- 4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

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

Incontestability: *When can the Life Insurance Benefit, excluding Accelerated Benefit, of The Policy be contested?*

Except for non-payment of premiums, Your Life Insurance Benefit, excluding Accelerated Benefit, cannot be contested after two years from its effective date.

In the absence of fraud, no statement made by You relating to Your insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You.

All statements made by the Policyholder, the Employer or You under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

Time Limit on Certain Defenses: *What happens if facts are misstated?*

For Accelerated Benefits, After this Policy has been in force for a period of two years, no statements of the Employer contained in the application, and no statement relating to insurability made by any Active Employee eligible for coverage under The Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

Assignment: *Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

- 1) the right to make any contributions required to keep the insurance in force;
- 2) the right to convert; and
- 3) the right to name and change a beneficiary.

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

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

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

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

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

No action at law or in equity shall be brought to recover on The Policy prior to the expiration of 60 days after written Proof of Loss has been furnished in accordance with the requirements of The Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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

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

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

Insurance fraud occurs when You, and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You and/or the Employer perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*

If material facts about You were not stated accurately:

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

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Earnings means Your regular annual rate of pay, not counting commissions, bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at Work.

Employer means the Policyholder.

Injury means bodily injury resulting:

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

which occurs while You are covered under The Policy.

Loss resulting from:

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

is not considered as resulting from Injury.

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

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

not being used as a Common Carrier.

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

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

Physician means a person who is:

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

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

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

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

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

You or Your means the person to whom this Certificate of Insurance is issued.

**ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION**

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

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

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

1. Plan Name

Group Basic Term Life, Basic Accidental Death and Dismemberment Plan for employees of NUTANIX, INC..

2. Plan Number

LIFE - 501

ADD - 501

3. Employer/Plan Sponsor

NUTANIX, INC.
1740 Technology Drive, Suite 150
San Jose, CA 95110

4. Employer Identification Number

27-0989767

5. Type of Plan

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

6. Plan Administrator

NUTANIX, INC.
1740 Technology Drive, Suite 150
San Jose, CA 95110

7. Agent for Service of Legal Process

For the Plan

NUTANIX, INC.
1740 Technology Drive, Suite 150
San Jose, CA 95110

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

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

8. **Sources of Contributions (Life and Accidental Death and Dismemberment)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan.

9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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

11. **Labor Organizations**

None

12. **Names and Addresses of Trustees**

None

13. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

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

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and

other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

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

**Hartford Life and Accident Insurance Company
Hartford, Connecticut
Member of The Hartford Insurance Group**