

YOUR BENEFIT PLAN

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Maryland

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

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 <https://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 or our contracted claims administrator as follows:

The insurance carrier for the Policy is:

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

The Claims Administrator for the Policy is:

**WebTPA
P.O. Box 99906
Grapevine, TX 76099
1-866-547-4205**

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.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

Alaska:

1. The **Statements** provision, as shown in the **General Provisions** section of the Certificate, is not applicable to statements made with the intent to defraud.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to You.

Arizona:

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

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

California:

1. **NOTICE:** You and Your Dependent(s) may be required to be insured with major medical insurance in order to be eligible for coverage under the Policy.

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, does not apply to You.
3. **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
Web Address: www.insurance.ca.gov

Colorado:

1. The continuously insured exclusion period, described in the **Pre-Existing Condition Limitation** provision, if included in the **Limitations and Exclusions** section, is six (6) consecutive months.
2. The **Claim Appeal** provision will always include the following:

If a claim for benefits has been denied in whole or in part and all administrative remedies have been exhausted, the claimant is entitled to have the claim reviewed de novo (from the beginning) in any court with jurisdiction and to a trial by jury.

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

Connecticut:

1. **NOTICE:** THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE SHOWN IN THE BENEFIT SCHEDULE.

Florida:

1. **NOTICE:** The benefits under the Policy providing Your coverage are governed primarily by the laws of a state other than Florida, unless the issue state is Florida. Please contact the Policyholder with any questions.

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. The time period for **Treatment** described in the **Pre-Existing Condition** definition, if shown in the **Definitions** section, is six (6) consecutive months, unless if shown as less.
2. Childbirth and non-professional activity exclusions are not applicable to You, if shown in the **Exclusions** provision of the **Limitations and Exclusions** section of the Certificate.
3. Proof of a handicap or disability of a **Dependent Child**, if included in the **Definitions** section, will only be required at time of claim and no more than once per year thereafter.
4. You are entitled to receive benefits for up to 31 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.
5. **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**Web Address:** <http://insurance.illinois.gov/>

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to You.
3. 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.

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

Kansas:

1. The following requirement applies to You:

Policy Interpretation:

Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to US the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Therefore, We are a fiduciary for the Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under the Policy. This provision only applies where the interpretation of the Policy is governed by ERISA.

Maine:

1. **NOTICE:** If You have a Medicare supplement policy or major medical policy, this coverage may be more than You need. For information, call the Bureau of Insurance at (800) 300-5000.
2. **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.

3. You are entitled to cover Your **Dependent Child**, if available under the Policy, up to age 19, unless if shown as higher in the **Definitions** section of the Certificate.
4. You are entitled to receive benefits for up to 31 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.

Michigan:

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

Minnesota:

1. **Notice of Claim**, as shown in the **Claim Provisions** section, should be sent to:
WebTPA, Inc.,
P.O. Box 99906
Grapevine, TX 76099
Fax: (469) 417-1952.
2. Benefits will be paid immediately upon receipt of **Proof of Loss**.

Missouri:

1. The suicide/self-inflicted injury exclusion, if shown in the **Exclusions** provision of the **Limitations and Exclusions** section, is only applicable to those events that occur while the Covered Person is sane.

Montana:

1. The time period for **Treatment** described in the **Pre-Existing Condition** definition, if included in the **Definitions** section, is six (6) consecutive months, unless if shown as less.
2. You are entitled to cover Your **Dependent Child**, if available under the Policy, up to age 25, unless if shown as higher in the **Definitions** section of the Certificate.
3. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for Treatment of any illness or injury within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. The **Pre-Existing Condition Limitation**, if shown in the **Limitations and Exclusions** section, is not applicable to You.
2. There is no defined time period from which You must submit Proof of Loss should You be unable to reasonably provide it within the first 90 days.
3. You are entitled to receive benefits for up to 31 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.
4. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
5. **Notice: READ THIS CERTIFICATE CAREFULLY.** The Primary Insured has a 30-day right from the Coverage Effective Date to examine this Certificate. If the Primary Insured is not satisfied, it may be returned to Us within 30 days from receipt of this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.
6. Termination of coverage has no effect on benefits payable for Treatment that is received for a Covered Illness or Covered Injury, as applicable, while a Covered Person was insured under the Policy.
7. The following **Extension of Coverage While Disabled** provision is added to the **Extension of Coverage** section of the Certificate:

Extension of Coverage While Disabled

If You are Disabled when coverage would otherwise terminate because:

- 1) You are no longer eligible for insurance or are no longer in an Eligible Class; or
- 2) the Policy terminated;

coverage will be extended for 90 days after it would otherwise terminate, while Disability continues. Extended coverage will be limited to Hospital Confinements commencing for the Injury or Illness causing the Disability.

The following definitions apply to this provision:

Disabled, Disability means that a significant change in Your mental or physical functional capacity has occurred, as a result of which during the initial 12 months of continuous disability You are:

- 1) unable to perform the Material Duties of Your Regular Occupation; and/or
- 2) receiving disability benefits through a disability insurance plan (or equivalent) sponsored by the Policyholder.

Thereafter, You must be continuously unable to perform the Material Duties of any occupation for which You are or may reasonably become qualified based on education, training or experience. At all times while disabled, You must be under the care of a Physician or Medical Professional.

Material Duties means the essential functions, operations and tasks relating to an occupation, as it is normally performed in the general labor market in the United States economy that cannot be reasonably modified or omitted.

Regular Occupation means the occupation You routinely perform at the time Your Disability begins. Your regular occupation is:

- 1) not limited to Your specific position with the Policyholder; and
- 2) is inclusive of any similar position or activity based on job descriptions included in the most recent edition of the United States Department of Labor Dictionary of Occupational Titles (or equivalent source), as normally performed in the United States economy (not specific to any employer, location, area or region).

8. **Notice:** **This is a Limited Policy - Read it Carefully**

New Mexico:

1. You are entitled to cover Your **Dependent Child**, if available under the Policy, up to age 26.
2. **NOTICE TO CONSUMER: This is a limited benefit health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-3935 (TTY: 711)**
3. Benefits paid on behalf of a Covered Person under this Certificate shall be paid to the human services department when:
 - a. the human services department has paid or is paying benefits on behalf of the Covered Person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
 - b. payment for the services in question has been made by the human services department to the Medicaid provider; and
 - c. We are notified that the Covered Person receives benefits under the Medicaid program.
4. If You are covered under a Non-ERISA policy issued outside of New Mexico with a certificate effective date of January 1, 2019 or later, these additional requirements apply to you:

Consumer Complaint Notice

If you are resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding your claim, premium, or other matters pertaining to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/>

- A. Benefits payable under this Certificate will be paid immediately after Our receipt of due written **Proof of Loss**. If a claim is paid more than 45 days from receipt of required **Proof of Loss**, You are entitled to interest on that amount at the rate of 1 1/2 times the prime lending rate, as determined by the superintendent, for New Mexico banks per year during the period the claim is unpaid.

- B. **Legal Actions** may not start until 60 days after Proof of Loss has been given or more than 3 years after the time proof of loss is required to be given, unless otherwise required by law in Your or the claimant's jurisdiction of residence.
- C. **Physician** means a person who is:
 - a. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art recognized by New Mexico law;
 - b. licensed to practice in the jurisdiction where care is being given;
 - c. operating within the scope of his or her license; and
 - d. not the Covered Person or a Family Member.

You have full freedom of choice in the selection of a Hospital for care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice for the treatment of any Covered Illness or Covered Injury within the scope and limitations of his or her practice.

- D. If an unmarried child is age 26 or older and is:
 - a. incapable of self-sustaining employment because of an intellectual disability or physical handicap;
 - b. chiefly dependent on You for financial support;
 and You have provided proof of his/her disability upon Our request, that child will continue to be a **Dependent Child** until these conditions cease to exist. We may request that proof of such incapacity and dependency is furnished to us within 31 days of the child's attainment age 26 and subsequently as may be required by us, but not more frequently than annually after the two year period following the child's attainment age of 26.

E. **Newborn and Newly Adopted Child Coverage:**

If, while covered under the Policy, You:

- a. have a newborn child;
- b. adopt a child;
- c. receive a stepchild; or
- d. become the legal guardian of a child;

the child will become covered under the Policy for 31 days after the date the child becomes eligible. Benefits and amounts will be the minimum amount for those We are providing for Dependent Child(ren) under the Policy at that time.

Coverage of the new child will cease after 31 days from the date the child became eligible unless You:

- a. enroll the new child prior to the expiration of the 31 days; and
- b. pay the additional required premium.

- F. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for **Dependent** coverage.
- G. Absent a showing of intentional fraud, no statement concerning insurability made by any **Covered Person** shall be used to contest the validity of the insurance for which the statement was made after this Policy has been in force for two years. In order to be used, the statement must be in writing and signed by the person making the statement. However, We are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this Policy, or upon other provisions in the Policy.

North Carolina:

1. **NOTICE:** Important Cancellation Information – Please Read the provision entitled, **Termination of Coverage** found in the **Termination** section of the Certificate.
2. **NOTICE:** NO RECOVERY FOR **PRE-EXISTING CONDITIONS** – READ CAREFULLY. No benefits will be provided during the **Pre-Existing Condition Limitation** period of the Policy **for Pre-Existing Conditions**, if defined in the Certificate.
3. No statements will be used to reduce or deny a claim if the Covered Person has been insured under the Policy for at least 2 years. Prior to 2 years, such statement must be in writing and signed by the Covered Person in order to be used.
4. **Notice of Claim**, as shown in the **Claim Provisions** section, should be sent to:
WebTPA, Inc.,
P.O. Box 99906
Grapevine, TX 76099
Fax: (469) 417-1952.
5. **Proof of Loss**, as shown in the **Claim Provisions** section, must be provided within 180 days from the date of loss.

6. Benefits will be paid immediately upon receipt of **Proof of Loss**.

North Dakota:

1. Termination of coverage has no effect on benefits payable for Treatment that is received for a Covered Illness or Covered Injury or for a Confinement that begins while any Covered Person was insured under the Policy.

Oregon:

1. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for **Dependent Child(ren)** coverage, if available in the **Definitions** section.

Rhode Island:

1. You are not limited in the legal action that may be taken in accordance with any applicable state or federal law. Please refer to the **Policy Interpretation** provision, if shown in the **General Provisions** section.
2. You are entitled to continue coverage for a period of at least 5 but not greater than 30 consecutive days should Your Dependent enter into active military service outside of the continental United States. Please see the Policyholder for additional eligibility requirements.

South Dakota:

1. The definition of **Physician**, as shown in the **Definitions** section of the Certificate, includes a Family Member if such person is the only doctor in the area acting within the scope of practice.

Texas:

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. Proof of disability or handicap of a **Dependent Child**, if shown the **Definitions** section, will not be requested more frequently than at time of claim and once every year thereafter.
2. The requirement to be charged, as referenced in the **Inpatient** definition, is not applicable if You are Confined in Veteran's Administration Hospital or other Federal Government Hospital.

Virginia:

1. **For Your Questions and Complaints:**
State Corporation Commission
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

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)

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GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.



Policyholder: LIMRiCC

Policy Number: VHI-891881

Policy Effective Date: July 1, 2023

Policy Anniversary: January 1

We have issued the Policy to the Policyholder. The Policy is delivered in and governed by the laws of the state of Illinois, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy that are important to the Covered Person(s) 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 previously issued to the Primary Insured 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 Hartford Life and Accident Insurance Company at Hartford, Connecticut.

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

Notice to Buyer: This is a hospital confinement indemnity policy. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. The Policy does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

The Policy may provide payment of several benefits as a result of claims from a single hospitalization or covered incident. Payment of one benefit under the Policy does not constitute acceptance of liability for all claims made under the Policy nor does it prohibit Us from further investigation of subsequent claims.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If a Covered Person is eligible for Medicare, he/she should review the Guide to Health Insurance for People with Medicare available from Us.

READ THIS CERTIFICATE CAREFULLY. The Primary Insured has a 30-day right from the Coverage Effective Date to examine this Certificate. If the Primary Insured is not satisfied, it may be returned to Us within 30 days from receipt of this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.

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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BENEFIT SCHEDULE

Eligible Class(es)

All Part-time Active Employees

Coverage Type

24 hour for Illness and Injury/Accident

Coverage Election

In order to be insured under the Policy an Employee must elect coverage for him/herself and any Dependent(s).

The Employee is required to pay premium for the coverage elected.

Eligibility Waiting Period

12 months

Other Hospital Indemnity Policy Limitation (Over-insurance Limitation)

Included

Disclosure of Services

In addition to the insurance coverage, We may offer noninsurance benefits and services to Employees.

BENEFIT(S) TABLE

Benefit:	Plan 2 Benefit Amount:
Hospital Care Benefit(s)	
First Day Hospital Confinement	\$1,000 per day
Daily Hospital Confinement (day 2 forward)	\$150 per day
Daily ICU Confinement (day 2 forward)	\$300 per day

DEFINITIONS

Accident means a sudden, unexpected and unforeseeable event that occurs while a Covered Person is insured under the Policy and results in one or more Injuries.

Actively at Work, Active Work means that an Employee is:

- 1) performing all the regular duties of his/her job for the Policyholder in the usual way for 30 or more hours each week; and
- 2) receiving compensation from the Policyholder for work performed.

An Employee is considered actively at work on any day that is not his/her regular scheduled workday (e.g., vacation or holiday) as long as the Employee was actively working on his/her last preceding regular scheduled workday.

Additional Enrollment Event means a period of time designated for enrollment under the Policy, other than an Annual Enrollment Period, as agreed to in writing by Our authorized representative in our Home Office.

Ambulatory Surgical Center (ASC) means a licensed healthcare facility where Surgical Procedures that do not require an overnight Hospital stay are performed by a Physician. The facility must:

- 1) be under the direct supervision of a Physician;
- 2) provide Treatment by Physicians and/or Medical Professionals; and
- 3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Annual Enrollment Period means a period of time during which annual benefits enrollment occurs each year as determined by the Policyholder.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable, and limitations and exclusions that apply to coverage.

Change in Family Status means one of the following events:

- 1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
- 2) You and Your Spouse divorce or legally terminate Your relationship;
- 3) Your Spouse dies;
- 4) You acquire a child who satisfies the definition of Dependent Child;
- 5) Your child no longer satisfies the definition of a Dependent Child or dies;
- 6) Your Spouse is no longer employed, which results in a loss of hospital indemnity insurance sponsored by the Spouse's employer for You or any Dependent(s); or
- 7) You change work classification from part-time to full-time or from full-time to part-time.

Civil Union means a legal relationship between two persons established pursuant to The Religious Freedom Protection and Civil Union Act, or a substantially similar relationship entered into in another jurisdiction, which allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, responsibilities, protections, benefits and legal rights provided to married heterosexual couples.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; pre-eclampsia; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; any condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 20 consecutive hours. This definition does not include a newborn child's initial Confinement in a Hospital following birth for routine medical and nursing care.

Confined Elsewhere means a Dependent is unable to perform, unaided, the normal functions of daily living, or leave his/her home or other place of residence without assistance.

Congenital Anomaly(ies) means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purposes of this definition, the term significant deviation is defined to be a deviation that impairs the function of the body, and includes but is not limited to the conditions of: cleft lip; cleft palate; defects of metabolism; sixth toes or fingers; webbed fingers or toes; or other conditions that are medically diagnosed to be congenital anomalies.

Covered Illness means an Illness for which Treatment is received while a Covered Person is insured under the Policy that is not excluded or limited by name, description or any other provision of the Policy.

Covered Injury means an Injury that is the direct result of an Accident that is not excluded or limited by name, description or any other provision of the Policy.

Covered Person means the Employee and any Dependent(s) who is/are currently insured under the Policy and this Certificate.

Custodial Care means non-medical care, either at home or in a nursing or assisted-living facility, that helps a person with activities of daily living (bathing, continence, dressing, eating, toileting and transferring) not requiring the constant attention of medical personnel, including the self-administration of medication.

Dependent Child(ren) means:

- 1) an Employee's or Spouse's natural child, legally adopted child or stepchild;
- 2) a child placed into the Employee's or Spouse's custody for adoption (regardless of whether the adoption has become final) or a child residing with the Employee pursuant to an interim court order of adoption;
- 3) a child for whom the Employee or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent;
- 4) an Employee's or Spouse's foster child or any other child for whom the Employee or Spouse has been appointed legal guardian; or
- 5) any other child who lives with the Employee in a regular parent/child relationship and is dependent on the Employee for support and maintenance;

who is/are under 26 years of age.

If an unmarried child is age 26 or older and is:

- 1) incapable of self-sustaining employment because of a mental or physical disability;
- 2) chiefly dependent on the Employee or Spouse for financial support and maintenance;

and proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

If a child is under age 30 and:

- 1) is a resident of Illinois;
- 2) has served in the active or reserve components of the United States Armed Forces (including the National Guard); and
- 3) has received a release or discharge other than dishonorable;

that child will continue to be a dependent child until these conditions cease to exist.

Dependent, Dependents means an Employee's Spouse and Dependent Child(ren).

Eligibility Waiting Period means the period of time an Employee must be a member in an Eligible Class before he/she is eligible to become insured, as shown in the Benefit Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

- 1) be staffed and equipped to handle trauma;
- 2) be under the direct supervision of a Physician;
- 3) provide Treatment by Physicians and/or Medical Professionals; and
- 4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Employee means a person who:

- 1) is a citizen or legal resident of the United States (including its territories and protectorates); or
- 2) is lawfully and legally able to work in the United States pursuant to applicable law(s); and
- 3) works for the Policyholder on a regular basis in the usual course of the Policyholder's business.

This definition does not include a person working for the Policyholder:

- 1) on a temporary, leased or seasonal basis;
- 2) as an independent contractor (including persons for whom income is reported on a 1099 form);
- 3) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
- 4) who resides outside the United States for a period in excess of 12 months, unless written approval has been received from Us.

Family Member means a Covered Person's Spouse (current and former); domestic partner (or equivalent); child; sibling; parent; grandparent; grandchild; aunt; uncle; first cousin; nephew; niece; or the spouse or domestic partner (or equivalent) of such individuals. This includes adopted, in-law and step-relatives, and anyone living in the Covered Person's household.

Home Office means Our office at One Hartford Plaza, Hartford, Connecticut 06155.

Hospital means an institution:

- 1) licensed to operate as a hospital pursuant to law;
- 2) primarily and continuously engaged in providing or operating either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and Treatment of sick or injured persons on an in-patient basis for which a charge is made; and
- 3) providing 24-hour nursing service by or under the supervision of registered nurses (RNs).

Hospital does not include:

- 1) convalescent homes, or convalescent, rest or nursing facilities;
- 2) facilities affording primarily custodial, educational or rehabilitative care;
- 3) facilities primarily for care of the aged/elderly, care of persons with Substance Use Disorders, or care of persons with Mental and Nervous Disorders; or
- 4) a distinct unit within a hospital that primarily treats or is dedicated to the care of persons with Substance Use Disorders or Mental and Nervous Disorders.

Illness means a physical or mental condition, disease, disorder, illness or infection, including normal pregnancy and childbirth and Complications of Pregnancy, that is not caused solely by nor is the result of an Accident. This definition includes organ donation and quarantine in a Hospital due to an identifiable exposure to a life-threatening contagious and/or infectious disease.

Injury or Injuries means bodily damage or harm that must be independent of Illness or bodily infirmity, including medical or surgical Treatment thereof.

Inpatient means a Covered Person who is Confined and charged by a medical facility for room and board. The requirement that a Covered Person be charged by the medical facility does not apply to confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of medical care and:

- 1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- 2) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- 3) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
- 4) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
- 5) has a Physician assigned to the unit on a full-time basis.

An intensive care unit may include Hospital units with the following (or similar) names: burn unit, critical care unit, neonatal intensive care unit, or transplant unit.

An intensive care unit is not any of the following step-down units: intermediate care unit, modified/moderate care unit, Observation Unit, progressive care unit, or sub-acute intensive care unit.

This definition does not include a private monitored room.

Medical Professional means a person who is appropriately licensed to provide medical care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include a Covered Person or any Family Member.

Mental and Nervous Disorder(s) means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Use Disorders.

Observation Unit means a specified unit within a Hospital, apart from an Emergency Room (ER), where a patient can be monitored by a Physician or Medical Professional following Treatment in an ER or as an Outpatient. This area must:

- 1) be under the direct supervision of a Physician;
- 2) provide Treatment by Physicians and/or Medical Professionals; and
- 3) provide care 24 hours per day, 7 days per week.

Other Hospital Indemnity Policy means any other hospital indemnity or fixed indemnity policy of insurance, underwritten by The Hartford®, that provides coverage for any of the same or similar benefits covered under this Certificate and Policy.

Outpatient means a Covered Person who receives Treatment or services at a Hospital, Ambulatory Surgical Center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling of their own authority with intent to mutually assist one another in an illegal or legal act. For purposes of this definition, a riot includes an insurrection or rebellion.

Physician means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or where required by state law, any other legally qualified practitioner of healing art;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) operating within the scope of his or her license; and
- 4) not the Covered Person or a Family Member.

Policy means the policy that We issued to the Policyholder under the Policy Number shown on the face page.

Policy Year means the period commencing at 12:00:00 a.m. on the Policy Effective Date and ending at 11:59:59 p.m. the day before the next succeeding Policy Anniversary and thereafter, each 12-month period commencing on the Policy Anniversary.

Primary Insured means an Employee who is currently insured under the Policy and this Certificate. (See also You, Yours.)

Spouse means any individual who, under applicable state law, is recognized as the spouse of an Employee.

Spouse also includes any individual who is a partner to an Employee in a Civil Union or domestic partnership, or other relationship as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in the Employee's jurisdiction of residence, if:

- 1) an Employee provides acceptable evidence that the requirements of the jurisdiction in which he/she resides for the establishment of the relationship have been met;
- 2) an Employee submits a written declaration of partnership signed by both parties acceptable to Us; or
- 3) the Employee and his/her partner satisfy the Policyholder's requirements for such partnerships.

Substance Use Disorder means the harmful or hazardous use of and dependence on psychoactive substances, including alcohol and illicit drugs.

Surgical Procedure means a medical procedure requiring an incision and manipulation (typically with instruments) performed on a person's body to repair damage or arrest disease.

Therapist means a person who is appropriately licensed to practice and provide occupational therapy, physical therapy or speech therapy. Any therapist must be acting within the scope of his/her license. A therapist does not include a Covered Person or any Family Member.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Urgent Care Facility means a licensed, freestanding healthcare facility providing immediate, short-term medical care without an appointment, other than a Hospital (including any Outpatient department of a Hospital), Emergency Room, or Physician or Medical Professional's office/clinic. The facility must:

- 1) be under the direct supervision of a Physician; and
- 2) provide Treatment by Physicians and/or Medical Professionals.

We, Us, Our means Hartford Life and Accident Insurance Company.

You, Yours means an Employee who is currently insured under the Policy and this Certificate. (See also Primary Insured.)

ELIGIBILITY AND EFFECTIVE DATES

Eligibility for Coverage

An Employee will become eligible for coverage under the Policy on the latest of:

- 1) the Policy Effective Date;
- 2) the date he/she becomes a member of an Eligible Class; or
- 3) the date he/she completes the Eligibility Waiting Period.

A Dependent will become eligible for coverage under the Policy on the later of:

- 1) the date the Employee becomes insured under the Policy; or
- 2) the date You acquire the Dependent.

If an Employee is hired as a part-time or temporary Employee and later becomes a full-time Employee, credit toward the Eligibility Waiting Period will be given for any period of time spent as a part-time or temporary Employee.

If more than one person within an immediate family unit is eligible for coverage under the Policy as an Employee of the Policyholder, then:

- 1) neither Employee may be covered as a Dependent of the other person; and
- 2) Dependent Child(ren) may only be covered as a Dependent of one Employee.

The date on which an Employee or Dependent becomes eligible for coverage may not be the same date on which insurance begins. The Coverage Effective Date provision describes the date on which insurance begins.

Initial Enrollment

An Employee must enroll for coverage for the Employee and any Dependent(s) within 31 days following the day the Employee or Dependent(s) first become(s) eligible for coverage under the Policy.

If an Employee does not elect coverage during the Employee's or Dependent's initial enrollment period, future enrollment may only occur as provided in the Changes in Coverage provision.

Coverage Effective Date

Coverage will start on the latest to occur of:

- 1) the first day of the month following the date an Employee or Dependent becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
- 2) the Policy Anniversary on or next following the last day of an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
- 3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or

- 4) the first day of the month following the date an Employee or Dependent is enrolled.

In no event will Dependent insurance become effective before an Employee becomes insured. An initial period of coverage for a new Dependent may be available under the New Dependent Coverage provision.

The Coverage Effective Date for any Employee or Dependent is subject to the Deferred Coverage Effective Date provision.

Deferred Coverage Effective Date

All Coverage Effective Dates, Changes in Coverage effective dates and Reinstatement of Coverage effective dates for an Employee and any Dependent(s) will be deferred if an Employee is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the day after the date the Employee has completed one full day of Active Work.

All Coverage Effective Dates, Changes in Coverage effective dates, New Dependent Coverage effective dates and Reinstatement of Coverage effective dates for a Dependent will also be deferred if on the date the Dependent is to become covered, he or she is Confined or Confined Elsewhere. Such coverage will not start until the day after the Dependent:

- 1) is no longer Confined or Confined Elsewhere; and
- 2) has engaged in all of the normal and customary activities of a person of like age, gender and good health for at least 15 consecutive days.

In no event will Dependent insurance become effective before an Employee becomes insured.

This provision does not apply to:

- 1) any newborn Dependent Child, regardless of Confinement; or
- 2) any disabled child who qualifies under the definition of Dependent Child(ren).

Changes in Coverage

An Employee may elect, drop, increase, decrease or otherwise change coverage only:

- 1) during an Annual Enrollment Period or any Additional Enrollment Event; or
- 2) within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on:

- 1) the Policy Anniversary on or next following the last day of an Annual Enrollment Period, if the change is requested during such period;
- 2) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
- 3) the date on which the change is requested following a Change in Family Status;

subject to the Deferred Effective Date provision.

An initial period of coverage for a new Dependent may be available under the New Dependent Coverage provision.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the date of the request or change.

New Dependent Coverage

If You:

- 1) marry or enter a partnership with an individual who satisfies the definition of Spouse; or
- 2) have a newborn or acquire a child who satisfies the definition of Dependent Child(ren);

while covered under the Policy, the new Dependent will be automatically covered under the Policy for 31 days from the date of birth, marriage, partnership or acquisition, subject to the Deferred Coverage Effective Date provision.

If Dependent coverage requires an election under the Policy, You must enroll the Dependent for coverage subject to the Changes in Coverage Provision in order for the Dependent to remain insured beyond the initial 31 day period.

TERMINATION OF COVERAGE

Termination of Coverage

Coverage for You and any Dependent(s) will end on the earliest of the following:

- 1) the last day of the month during which You become no longer eligible for insurance under any provision of the Policy;

- 2) the last day of the month during which You are no longer in an Eligible Class or the Policy no longer covers Your class;
- 3) the last day of the month during which You request We terminate coverage, subject to the Changes in Coverage provision;
- 4) the date the required premium is due but not paid; or
- 5) the date the Policy terminates.

Coverage for a Dependent will also end on the last day of the month during which a Dependent no longer satisfies the definition of Spouse or Dependent Child(ren).

When coverage would otherwise end, You or an insured Spouse, in certain circumstances may be able to continue insurance for You and any Dependent Child(ren):

- 1) under a Continuation provision; or
- 2) through the Portability provision.

Termination of coverage has no effect on benefits payable for Treatment that is received for a Covered Illness or Covered Injury while a Covered Person was insured under the Policy.

REINSTATEMENT OF COVERAGE

Reinstatement of Coverage

Coverage for an Employee and any previously insured Dependent(s) under the Policy may be reinstated after it ends if the Employee:

- 1) returns to an Eligible Class within 12 months from the date coverage ended; and
- 2) requests reinstatement with 31 days from his/her return to an Eligible Class, if coverage requires an election under the Policy;

except for coverage that ended due to non-payment of premium or voluntary termination of coverage by an Employee.

We will credit any time the Employee and any Dependent(s) were previously insured under the Policy toward the satisfaction of the Eligibility Waiting Period.

Reinstated coverage will become effective on the first day of the month following the date on which the reinstatement is requested, subject to the Deferred Coverage Effective Date provision.

Reinstated coverage is subject to all other terms and provisions of the Policy.

If coverage ended due to non-payment of premium or voluntary termination of coverage by an Employee, reinstatement is not available and the Employee may not re-enroll until the next Annual Enrollment Period or Additional Enrollment Event occurs.

Reinstatement is also not available for coverage that an Employee or any Dependent(s) continued under the Portability provision unless such coverage is cancelled or surrendered.

CONTINUATION

Continuation

You may be able to continue coverage for You and any Dependent(s) in certain circumstances when You are no longer Actively at Work. The Continuation Options are explained below.

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:

- 1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf);
- 2) the Policyholder must approve the continuation; and
- 3) if You are eligible for more than one Continuation Option:
 - a) the continuation time periods will not be applied consecutively; and
 - b) the longest applicable continuation time period from the date You were last Actively at Work will apply.

Coverage continued under this provision will end on the last day of the month on or next following the earliest of the day:

- 1) the applicable continuation time period has expired, as described in the Continuation Options;
- 2) You return to Active Work for the Policyholder; or
- 3) You begin full-time employment with an employer other than the Policyholder.

Coverage continued under this provision will also end in accordance with the Termination of Coverage provision. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

Continuation Option(s)

Leave of Absence: If You are on a leave of absence approved by the Policyholder due to any personal reason, coverage may be continued for up to 3 month(s) from the date You ceased Active Work.

Federal and/or State Laws: The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain circumstances for medical leaves of absence, military leaves of absence, other leaves of absence, layoff or termination of employment.

If You are not Actively at Work and are eligible to continue insurance under one of these laws, coverage may be continued for up to the time period allowed by the law that enables the continuation. Contact the Policyholder for additional information regarding continuation options that may be available through federal and/or state laws.

Illness or Injury: If You are not Actively at Work due to Illness or Injury, coverage may be continued for up to 12 month(s) from the date You ceased Active Work.

Dependent Continuation: If You die while covered under the Policy, coverage for Your Dependents in force at the time of Your death may be continued for a period of 90 days from the date of Your death.

Layoff: If You are subject to a temporary involuntary layoff by the Policyholder, coverage may be continued for up to 3 month(s) from the date You ceased Active Work. If the layoff becomes permanent, this continuation will cease.

PORTABILITY

Portability

You or Your insured Spouse, in certain circumstances, may continue coverage under a group portability policy when coverage ends under the Policy. The terms, conditions and premium rates of the portability coverage will be governed by the portability policy and may not be the same as those under this Certificate.

If You are age 79 or younger, You may request portability coverage for You and any insured Dependent(s) when:

- 1) You are no longer Actively at Work and are not eligible for coverage under any other Continuation provision in this Certificate;
- 2) You are no longer employed by the Policyholder, including retirement; or
- 3) the Policy terminates and the Policyholder does not obtain a replacement policy with another insurance carrier within 31 days.

If You are eligible to request portability coverage, then You must elect insurance under the portability policy in order for any Dependent(s) to be eligible for coverage under the portability policy.

An insured Spouse who is age 79 or younger may request portability coverage for him/herself and any insured Dependent Child(ren):

- 1) in the event of Your death;
- 2) in the event of divorce, dissolution of partnership or legal separation from You; or
- 3) when You enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the Policy as an Employee.

If an insured Spouse elects coverage under the portability policy, the Spouse will become the primary insured under the portability policy. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

Electing Portability

When coverage under the Policy ends, notice of the right to request portability coverage will be given. To elect coverage under a group portability policy, You or Your insured Spouse must send a request to Us. The benefits and premium rates of the portability policy are described on Our portability request form, which can be obtained by contacting the Policyholder or Us.

The request and the initial premium due must be received within 31 days after insurance under the Policy ends. If timely notice is not given, an extension of the period of time in which to request portability coverage will be allowed. You or Your

Spouse will have 15 days from the date notice is received to submit his/her request and initial premium. However, in no event will a request be accepted by Us if received more than 91 days after the date coverage under the Policy would otherwise end, even if notice is not received.

The continued group insurance coverage under the portability policy is available as a result of portability rights that arise solely from the Policy, as arranged for the Employee as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS

HOSPITAL CARE BENEFITS

First Day Hospital Confinement Benefit

We will pay the First Day Hospital Confinement Benefit Amount shown in the Benefit Schedule for the first day a Covered Person is Confined to a Hospital as an Inpatient as the result of a Covered Illness or Covered Injury.

The Confinement must begin within 90 days after the Covered Illness or Covered Injury occurs. This benefit is payable once per Covered Illness or Covered Injury, and is payable once per Policy Year for each Covered Person. This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Illness or Covered Injury.

This benefit is not payable:

- 1) for Treatment in an Emergency Room, as an Outpatient, in an Observation Unit or other observation area of a Hospital, or for a Hospital stay of less than 20 hours; or
- 2) if a Covered Person is discharged from the Hospital and again becomes an Inpatient for the same or related Covered Illness or Covered Injury.

If more than one type of Confinement occurs for a Covered Person for the same day (regardless of the medical facility(ies)), only the highest Confinement benefit is payable.

Daily Hospital Confinement Benefit

We will pay the Daily Hospital Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined to a Hospital as an Inpatient as the result of a Covered Illness or Covered Injury, beginning on the second day of Confinement.

The Confinement must begin within 90 days after the Covered Illness or Covered Injury occurs. This benefit is payable for up to 90 days per Policy Year for each Covered Person. This benefit is only payable once per day, even if the Confinement is the result of more than one Covered Illness or Covered Injury.

This benefit is not payable for:

- 1) any day for which a First Day Hospital Confinement benefit is payable; or
- 2) Treatment in an Emergency Room, as an Outpatient, in an Observation Unit or other observation area of a Hospital, or for a Hospital stay of less than 20 hours.

If more than one type of Confinement occurs for a Covered Person for the same day (regardless of the medical facility(ies)), only the highest Confinement benefit is payable.

Daily ICU Confinement Benefit

We will pay the Daily ICU Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined to an Intensive Care Unit (ICU) as the result of a Covered Illness or Covered Injury, beginning on the second day of Confinement.

The ICU Confinement must begin within 90 days after the Covered Illness or Covered Injury occurs. This benefit is payable for up to 30 days per Policy Year for each Covered Person. This benefit is only payable once per day, even if the ICU Confinement is the result of more than one Covered Illness or Covered Injury.

If more than one type of Confinement occurs for a Covered Person for the same day (regardless of the medical facility(ies)), only the highest Confinement benefit is payable.

LIMITATIONS AND EXCLUSIONS

Other Hospital Indemnity Policy Limitation (Over-insurance Limitation)

If You are insured under any Other Hospital Indemnity Policy, any claim for benefit is only payable under the one policy elected by You (or Your beneficiary or estate, in the event of death).

We will return the amount of premium paid for any Other Hospital Indemnity Policy that is declined by You retroactive to the later of:

- 1) the last date any benefit was paid for any Covered Person under the Other Hospital Indemnity Policy; or
- 2) the effective date of insurance for You under the Other Hospital Indemnity Policy.

Exclusions

No benefits are payable under the Policy for any Illness or Injury that results from or is caused by a Covered Person's:

- 1) suicide or attempted suicide, whether sane or insane, or intentional self-infliction;
- 2) intoxication (as defined by the law of the jurisdiction in which the Illness or Injury occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a Physician or Medical Professional;
- 3) voluntary commission of or attempt to commit a felony, voluntary Participation in a Riot, or voluntary engagement in an illegal occupation;
- 4) incarceration or imprisonment following conviction for a crime;
- 5) travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight or while traveling on business of the Policyholder;
- 6) ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing;
- 7) participation in any organized sport in a professional or semi-professional capacity;
- 8) participation in abseiling, base jumping, Bossaball, bouldering, bungee jumping, cave diving, cliff jumping, free climbing, freediving, freerunning, hang gliding, ice climbing, Jai Alai, jet powered flight, kite surfing, kiteboarding, lugging, missed climbing, mountain biking, mountain boarding, mountain climbing, mountaineering, parachuting, paragliding, parakiting, paramotoring, parasailing, Parkour, proximity flying, rock climbing, sail gliding, sandboarding, scuba diving, sepak takraw, slacklining, ski jumping, skydiving, sky surfing, speed flying, speed riding, train surfing, tricking, wingsuit flying, or other similar extreme sports or high risk activities;
- 9) travel or activity outside the United States or Canada;
- 10) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate; or
- 11) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer.

If You notify Us of active duty service or training, We will refund any premiums paid for any period for which no coverage is provided as a result of the exclusion.

In addition, We will not pay for any benefits under the Policy, unless required by law for:

- 1) elective abortion or complications thereof;
- 2) artificial insemination, in vitro fertilization, test tube fertilization;
- 3) sterilization, tubal ligation or vasectomy, and reversal thereof;
- 4) aroma therapeutic, herbal therapeutic, or homeopathic services;
- 5) medical mishap or negligence on the part of any Physician, Medical Professional, or Therapist, including malpractice;
- 6) Treatment, supplies or services provided by, through or, on behalf of any government agency or program, unless payment is required by a Covered person;
- 7) Custodial Care, unless specifically allowed by a benefit provision in this Certificate or any rider attached to the Policy (if applicable);
- 8) elective or cosmetic surgery or procedures, except for reconstructive surgery:
 - a) incidental to or following surgery for disease, infection or trauma of the involved body part; or
 - b) due to Congenital Anomaly or disease of a Dependent Child which has resulted in a functional defect; and
- 9) dental care or Treatment, except for:
 - a) Treatment due to an Injury to sound natural teeth within 12 months of the Accident; and
 - b) Treatment necessary due to congenital disease or anomaly.

Congenital Anomalies of newborn and newly adopted children are not excluded if otherwise covered under the terms of the Policy.

CLAIM PROVISIONS

Notice of Claim

Notice of claim may be given to Us within 20 days after the start of any loss covered by the Policy, or as soon as reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

Failure to give notice within this time frame will not invalidate nor reduce any claim.

Notice of claim may be submitted:

- 1) via mail to The Hartford Hospital Indemnity Benefit Department, PO Box 99906, Grapevine, TX;
- 2) via fax to (469) 417-1652; or
- 3) per the instructions included on the applicable form.

Claim Forms

When We receive Notice of Claim, We will send claim forms. If the claimant does not receive the forms within 15 days after Notice of Claim is sent, Proof of Loss may be sent to Us without waiting to receive the claim forms.

Proof of Loss

The claimant must send proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Physical Examinations and Autopsy

We, at our own expense, shall have the right and opportunity to have:

- 1) a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
- 2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims

Benefits payable under the Policy will be paid upon Our receipt of due Proof of Loss. If payment is not made within 30 days following Our receipt of satisfactory Proof of Loss, then You are entitled to interest at the rate prescribed by law from the 30th day after receipt of such proof to the date of payment.

Payment of Claims

All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:

- 1) Your designated beneficiary(ies); or if none, then to
- 2) Your estate.

Beneficiary Designation

In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept.

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Change of Beneficiary

The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

Claim Denial

If a claim for benefits is denied, the claimant 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 Policy provisions on 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

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

- 1) must submit a written request for review within:
 - a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of a Covered Illness or Covered Injury; or
 - b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of a Covered Illness or Covered Injury or other loss; 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.

Overpayment Recovery

We have the right to recover from You or the recipient of benefits any amount that We determine to be an overpayment. You or the recipient of benefits has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
 - a) You;
 - b) any other person to or for whom payment was made; or
 - c) Your estate;
- 2) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made;
- 3) refer the unpaid balance to a collection agency; and
- 4) pursue and enforce all legal and equitable rights in court.

GENERAL PROVISIONS

Entire Contract

The Policy, the Policyholder's signed application, this Certificate and any riders, endorsements or other attached papers make up the entire contract of insurance between the Policyholder and Us.

Statements

All statements made by the Policyholder or any Covered Person are considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person, his or her beneficiary or personal representative.

Time Limit on Certain Defenses

Absent a showing of intentional fraud, no statement concerning insurability made by any Covered Person shall be used to contest the validity of the insurance for which the statement was made after this Policy has been in force for two years. In order to be used, the statement must be in writing and signed by the person making the statement. However, We are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this Policy, or upon other provisions in the Policy.

Legal Actions

No legal action may start:

- 1) until 60 days after Proof of Loss has been given; or

- 2) more than 3 years after the time Proof of Loss is required to be given; unless otherwise required by law in Your or the claimant's jurisdiction of residence.

Misstatement of Age

If the age of any Covered Person has been misstated:

- 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.

Assignment

You have the right to absolutely assign 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; and
- 2) 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 his/her rights and interest under the Policy.

Insurance Fraud

Insurance fraud occurs when any person and/or the Policyholder 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 a person and/or the Policyholder 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 a person and/or the Policyholder perpetrate insurance fraud.

Conformity with State and Federal Laws

Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Time Periods

Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

Workers' Compensation

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

Unpaid Premium

Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

Maryland

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

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 <https://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 or one of our contracted administrators as follows:

The insurance carrier for the policy is:

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

The Claims Administrator for the policy is:

**WebTPA
P.O. Box 99906
Grapevine, TX 76099
1-866-547-4205**

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.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

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. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. 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. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

California:

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

Eligibility Determination

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

- (a) obtain with the Covered Person's cooperation and authorization if required by law, only such information that is necessary to evaluate his/her claim and decide whether to accept or deny his/her claim for benefits. We may obtain this information from the Covered Person's Notice of Claim, submitted proofs of loss, statements, or other materials provided by the Covered Person or others on the Covered Person's behalf; or, at Our expense. We may obtain necessary information, or have the Covered Person physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at the Covered Person's option and at his/her expense, the Covered Person may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of the Covered Person's choice. The Covered Person should provide Us with all information that he/she want Us to consider regarding his/her claim;
- (b) as a 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;
- (c) if We approve the Covered Person's claim, We will review Our decision to approve his/her claim for benefits as often as is reasonably necessary to determine his/her continued eligibility for benefits;
- (d) if We deny the Covered Person's claim, We will explain in writing to the Covered Person the basis for an adverse determination in accordance with the Policy as described in the provision entitled Claim Denial.

In the event We deny the Covered Person's claim for benefits, in whole or in part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled **Claim Appeal**. If the Covered Person does 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
Web Address: www.insurance.ca.gov

Colorado:

1. Reference to fraud in the **Statements** provision, located in the **General Provisions** section, is not applicable.
2. The **Spouse** definition also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.
3. The **Payment of Claims** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, the Covered Person is entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

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

Florida:

1. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Idaho:

1. **Questions and Complaints:**
Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043

Illinois:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section, is not applicable.
2. **For Your Questions and Complaints**
Illinois Department of Insurance
Consumer Services Station
Springfield, IL 62767
Consumer Assistance: 1(866) 445-5364
Officer of Consumer Health Insurance: 1(877) 527-9431
Web Address: <http://insurance.illinois.gov/>
3. 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.

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
2. The term CONTRACT is replaced with CERTIFICATE in Medicare Supplement **NOTICE** found on the first page of the Certificate.

Kansas:

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

Policy Interpretation: Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1. The **Reinstatement after Military Service** provision, if not shown in the **Continuation Provisions** section, applies to you:

Reinstatement after Military Service: If:

(a) Your coverage terminates because You enter active military service; and
(b) You are rehired within 12 months of the date You return from active military service
then coverage for You may be reinstated, provided You request such reinstatement within 30 days of the date You return to work.

The reinstated coverage will:

- (a) be the same coverage amounts in force on the date coverage terminated; and
- (b) not be subject to any Waiting Period for Coverage; and
- (c) 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.

Michigan:

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

Minnesota:

1. **Notice of Claim**, as shown in the **Claim Provisions** section, should be sent to:
The Hartford Supplemental Insurance Benefit Department
P.O. Box 99906
Grapevine, TX 76099.
2. Payment of claim will occur immediately after Our receipt of due written Proof of Loss, regardless of what is stated in the **Time of Payment of Claims**, located in the **Claim Provisions** section of the certificate.

Missouri:

1. The term CONTRACT is replaced with CERTIFICATE in the Medicare Supplement **NOTICE** found on the first page of the Certificate.

Montana:

1. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language:
You have full freedom of choice in the selection of any health care provider for the treatment of any injury related to an Accident within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. Reference to fraud in the **Statements** provision located in the **General Provisions** section, is not applicable.
2. If it is not reasonably possible to give proof during the time period referenced in the **Proof of Loss** provision, located in the **Claim Provisions** section, then proof must be provided as soon as reasonably possible.
3. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
4. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
5. Felonious driving due to intoxication is excluded from benefit payment when "while driving due to intoxication" is referenced in the **Exclusions** provision.
6. **Notice: Right to Return This Certificate** - If, for any reason, you are not satisfied with this Certificate, you can return it to us at Our Home Office within 30 days after you receive it. At that time, you should ask us in writing to cancel it. We will consider this Certificate as if it never existed. Any premium paid will be refunded.
7. **Notice: This Policy does not insure against loss resulting from sickness.**
8. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
9. The following **Extension of Coverage while Disabled** provision is added to the **Continuation Provisions** section of the Certificate:

Extension of Coverage while Disabled

If You are Disabled when coverage would otherwise terminate because:

- (a) You are no longer eligible for insurance or are no longer in an Eligible Class; or
- (b) the Policy terminated;

coverage will be extended for 90 days after it would otherwise terminate, while Disability continues.

The following definitions apply to this provision:

Disabled, Disability means that a significant change in Your mental or physical functional capacity has occurred, as a result of which during the initial 12 months of continuous disability You are:

- (a) unable to perform the Material Duties of Your Regular Occupation; and/or
- (b) receiving disability benefits through a disability insurance plan (or equivalent) sponsored by the Policyholder.

Thereafter, You must be continuously unable to perform the Material Duties of any occupation for which You are or may reasonably become qualified based on education, training or experience. At all times while disabled, You must be under the care of a Physician or Medical Professional.

Material Duties means the essential functions, operations and tasks relating to an occupation, as it is normally performed in the general labor market in the United States economy that cannot be reasonably modified or omitted.

Regular Occupation means the occupation You routinely perform at the time Your Disability begins. Your regular occupation is:

- (a) not limited to Your specific position with the Policyholder; and
- (b) is inclusive of any similar position or activity based on job descriptions included in the most recent edition of the United States Department of Labor Dictionary of Occupational Titles (or equivalent source), as normally performed in the United States economy (not specific to any employer, location, area or region).

10. **Notice:** **This is a Limited Policy - Read it Carefully**

11. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

New Mexico:

1. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
2. Benefits paid on behalf of a Covered Person under this certificate shall be paid to the Human Services Department when:
 - a. the Human Services Department has paid or is paying benefits on behalf of the Covered Person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
 - b. payment for the services in question has been made by the Human Services Department to the Medicaid provider; and
 - c. We are notified that the Covered Person receives benefits under the Medicaid program and that benefits must be paid directly to the Human Services Department.
3. If You are covered under a Non-ERISA policy issued outside of New Mexico with a certificate effective date of January 1, 2019 or later, these additional requirements apply to you:

Consumer Complaint Notice

If you are resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding your claim, premium, or other matters pertaining to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:<https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/>

- A. Benefits payable under this Certificate will be paid immediately after Our receipt of due written **Proof of Loss**. If a claim is paid more than 45 days from receipt of required **Proof of Loss**, You are entitled to interest on that amount at the rate of 1 1/2 times the prime lending rate, as determined by the superintendent, for New Mexico banks per year during the period the claim is unpaid.
- B. **Legal Actions** may not start until 60 days after proof of loss is given or more than 3 years after the time proof of loss is required to be given.

- C. **Physician** means a person who is:
- a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art recognized by New Mexico law;
 - licensed to practice in the jurisdiction where care is being given;
 - operating within the scope of his or her license; and
 - not the Covered Person or a Family Member.

You have full freedom of choice in the selection of a Hospital for care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice for the treatment of any Injury related to an Accident within the scope and limitations of his or her practice.

- D. If an unmarried child is age 26 or older and is:
- incapable of self-sustaining employment because of an intellectual disability or physical handicap;
 - chiefly dependent on You for financial support;
- and You have provided proof of his/her disability upon Our request, that child will continue to be a **Dependent Child** until these conditions cease to exist. We may request that proof of such incapacity and dependency is furnished to Us within 31 days of the child's attainment age 26 and subsequently as may be required by Us, but not more frequently than annually after the 2 year period following the child's attainment age of 26.

E. **Newborn and Newly Adopted Child Coverage:**

If, while covered under the Policy, You:

- have a newborn child;
- adopt a child;
- receive a stepchild; or
- become the legal guardian of a child;

the child will become covered under the Policy for 31 days after the date the child becomes eligible. Benefits and amounts will be the minimum amount for those We are providing for Dependent Child(ren) under the Policy at that time.

Coverage of the new child will cease after 31 days from the date the child became eligible unless You:

- enroll the new child prior to the expiration of the 31 days; and
- pay the additional required premium.

- F. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child to be eligible for **Dependent** coverage.
- G. After a **Covered Person** has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period.

New York:

- NOTICE:** The insurance evidenced by this certificate provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

North Carolina:

- Notice of Claim**, as shown in the **Claim Provisions** section, should be sent to:
The Hartford Supplemental Insurance Benefit Department
P.O. Box 99906
Grapevine, TX 76099.
- Payment of claim will occur immediately after Our receipt of due written Proof of Loss, regardless of what is stated in the **Time of Payment of Claims**, located in the **Claim Provisions** section of the certificate.
- Proof of Loss**, as shown in the **Claim Provisions** section, must be provided within 180 days from the date of loss.
- Reference to fraud in **Time Limit on Certain Defenses** provision, located in the **General Provisions** section, is not applicable.

Oregon:

- We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a

dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.

2. The **Spouse** definition will always include domestic partners, civil unions, and any other arrangement allowable by state law.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section, is not applicable.
2. The following continuation requirement applies to you:
Family Military Leave of Absence: If Your spouse or child enters active full-time military service outside of the continental United States, Hawaii, Puerto Rico or Alaska, and You:
 - a) have been employed with the same employer for at least two years; and
 - b) have completed 1,250 hours of service during a 12 month period immediately prior to the date Military Leave of Absence would begin; and
 - c) have exhausted all the other time made available to You by Your Employer except sick time and short term disability;then Your coverage may be continued for up to 30 days. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

To elect a Family Military Leave of Absence, You must notify Your Employer at least 14 days prior to the date the leave would begin if the leave would consist of five or more consecutive work days. For a leave of less than five days, the Employee should give notice as soon as reasonable possible.

South Dakota:

1. The definition of **Physician** will include a Family Member if such person is the only doctor in the area acting within the scope of practice.

Texas:

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si

no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Virginia:

1. **For Your Questions and Complaints:**
State Corporation Commission
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

Washington:

1. **Accident Benefits and Accidental Death and Dismemberment Benefits** or covered expenses incurred because of an accidental injury shall be paid if the covered death occurs, or the covered services are incurred, within one year of the accident.

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)

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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



Will pay benefits according to the conditions of the Policy.

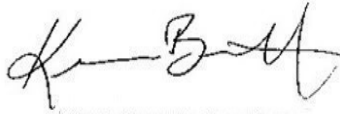
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

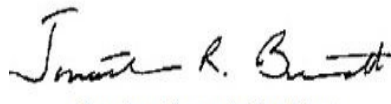
Policyholder: LIMRiCC
Policy Number: VAC-891881
Policy Issue State: Illinois

READ THIS CERTIFICATE CAREFULLY.

Hartford Life and Accident Insurance Company has issued and delivered a group insurance policy to the Policyholder shown above. This Certificate describes Accident insurance provided to Covered Persons under the Policy issued to the Policyholder.

Signed for Hartford Life and Accident Insurance Company at Hartford, Connecticut.


Kevin Barnett, *Secretary*


Jonathan Bennett, *President*

Notice to Buyer: The Policy provides Accident-only coverage and it does not pay benefits for loss from sickness. Review Your Certificate carefully.

The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

This Policy may provide payment of several benefits as a result of claims from a single Accident. Payment of one benefit for an Accident under this Policy does not constitute acceptance of liability for all claims made under the Policy nor does it prohibit Us from further investigation into the cause of or existence of an Accident for subsequent claims.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the Company.

**GROUP ACCIDENT INSURANCE CERTIFICATE
Non-Participating**

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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BENEFIT SCHEDULE

Policy Effective Date: July 1, 2023

Eligible Classes for Coverage: All Part-time Active Employees scheduled to work at least 20 hours per week and who are citizens or legal residents of the United States of America, its territories and protectorates; excluding temporary, leased or seasonal employees.

Waiting Period: 12 months

Plan Type: Voluntary Accident

Accident Type: On the Job & Off the Job Coverage

Disclosure of Services:

In addition to the insurance coverage, We may offer non-insurance benefits and services to Active Employees.

VOLUNTARY ACCIDENT BENEFITS

Description of Benefit	Benefit Amount
Accident Follow-Up Benefit	\$100
Acupuncture Benefit	\$50
Ambulance (Air) Benefit	\$2,000
Ambulance (Ground) Benefit	\$750
Blood/Plasma/Platelet Benefit	\$300
Child Care Benefit	\$35 per day
• Maximum Daily Benefit	\$100 per day
Chiropractic Care Benefit	\$50
Daily Hospital Confinement Benefit	\$400 per day
Daily ICU Confinement Benefit	\$600 per day
Diagnostic Exam Benefit	\$300
Emergency Dental Benefit (extraction)	\$150
Emergency Dental Benefit (crown)	\$450
Emergency Room Benefit	\$200
Hospital Admission Benefit	\$1,500
Initial Physician Visit Benefit	\$100
Lodging Benefit	\$150 per day
Medical Appliance Benefit	\$200
Physical Therapy Benefit	\$75 per day
Rehabilitation Facility Benefit	\$300 per day
Transportation Benefit	\$600 per trip
Urgent Care Benefit	\$150
X-Ray Benefit	\$150
Dislocations Benefit (open reduction)	
• Hip	\$8,000
• Knee (except patella)	\$5,000
• Ankle - bone/bones of the foot (other than toes)	\$5,000
• Collarbone (sternoclavicular)	\$2,000
• Lower jaw	\$2,000
• Shoulder (glenohumeral)	\$2,000
• Elbow	\$2,000
• Wrist	\$2,000
• Bone/bones of the hand (other than fingers)	\$1,500
• Collarbone (acromioclavicular and separation)	\$1,000
• One toe or finger	\$500
Dislocations Benefit (closed reduction)	
• Hip	\$4,000
• Knee (except patella)	\$2,500
• Ankle - bone/bones of the foot (other than toes)	\$2,500
• Collarbone (sternoclavicular)	\$1,000
• Lower jaw	\$1,000
• Shoulder (glenohumeral)	\$1,000
• Elbow	\$1,000
• Wrist	\$1,000
• Bone/bones of the hand (other than fingers)	\$750
• Collarbone (acromioclavicular and separation)	\$500
• One toe or finger	\$250
Dislocations Benefit (incomplete)	25% of the Dislocations Benefit (closed reduction)
Fractures Benefit (open reduction)	
• Skull (except bones of face or nose)	
• Depressed skull fracture	\$10,000
• Simple non- depressed skull fracture	\$4,000
• Hip, thigh (femur)	\$8,000
• Vertebrae, body of (excluding vertebral processes)	\$3,000

Description of Benefit	Benefit Amount
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	\$10,000
• Leg (tibia and/or fibula)	\$4,000
• Bones of face or nose (except mandible or maxilla)	\$1,500
• Upper jaw, maxilla (except alveolar process)	\$1,500
• Upper arm between elbow and shoulder (humerus)	\$2,000
• Lower jaw, mandible (except alveolar process)	\$1,500
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	\$4,000
• Vertebral processes	\$1,500
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	\$2,000
• Kneecap (patella)	\$3,000
• Foot (except toes)	\$1,500
• Ankle	\$2,000
• Rib	\$750
• Coccyx	\$750
• Finger, toe	\$500
Fractures Benefit (closed reduction)	
• Skull (except bones of face or nose)	
• Depressed skull fracture	\$5,000
• Simple non- depressed skull fracture	\$2,000
• Hip, thigh (femur)	\$4,000
• Vertebrae, body of (excluding vertebral processes)	\$1,500
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	\$5,000
• Leg (tibia and/or fibula)	\$2,000
• Bones of face or nose (except mandible or maxilla)	\$750
• Upper jaw, maxilla (except alveolar process)	\$750
• Upper arm between elbow and shoulder (humerus)	\$1,000
• Lower jaw, mandible (except alveolar process)	\$750
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	\$2,000
• Vertebral processes	\$750
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	\$1,000
• Kneecap (patella)	\$1,500
• Foot (except toes)	\$750
• Ankle	\$1,000
• Rib	\$375
• Coccyx	\$375
• Finger, toe	\$250
Chip Fracture	25% of Fractures Benefit (closed reduction)
Abdominal/Thoracic Surgery Benefit	\$3,000
Arthroscopic Surgery Benefit	\$500
Burn Benefit	
• Second Degree Burns	\$1,500
• Third Degree Burns	\$15,000
Skin Graft Benefit	50% of applicable burn benefit
Concussion Benefit	\$200
Eye Injury Benefit surgical repair	\$750
Eye Injury Benefit removal of foreign object	\$400
Hernia Benefit	\$400
Joint Replacement Benefit	\$4,000
Knee Cartilage Benefit (with repair)	\$2,000

Description of Benefit	Benefit Amount
Knee Cartilage Benefit (without repair)	\$500
Lacerations Benefit	
• 2" to 6" with sutures	\$500
• Greater than 6" with sutures	\$1,000
Ruptured Disc Benefit	\$2,000
Tendon/Ligament/Rotator Cuff Benefit	
• Single	\$1,000
• Two or more	\$2,000
Accidental Death Benefit	Primary Insured \$75,000
	Spouse \$37,500
	Dependent Child(ren) \$18,750
Accidental Death - Common Carrier Benefit	Primary Insured \$150,000
	Spouse \$75,000
	Dependent Child(ren) \$37,500
Accidental Dismemberment Benefit	
• Both hands or both feet or sight of both eyes	\$75,000
• One hand and One foot	\$75,000
• Speech and hearing in both ears	\$75,000
• Either hand or foot and sight of one eye	\$75,000
• Either hand or foot	\$37,500
• Sight of one eye	\$37,500
• Speech or hearing in both ears	\$37,500
• Thumb and index finger of either hand	\$10,000
Coma Benefit	\$15,000
Home Health Care Benefit	\$75 per day
Paralysis Benefit (Paraplegia)	\$37,500
Paralysis Benefit (Quadriplegia)	\$75,000
Prosthesis Benefit	
• Single	\$1,500
• Two or more	\$3,000

DEFINITIONS

Accident means a sudden, unforeseeable event that results in an Injury and that:

- (a) occurs while this Certificate is in force;
- (b) occurs while the Covered Person's insurance is effective; and
- (c) is not subject to any exclusion in the Policy.

Active Employee means an employee who works for the Policyholder on a regular basis in the usual course of the Policyholder's business.

This must be at least the numbers of hours shown in the Benefit Schedule.

Actively at Work means that You perform all the regular duties of Your job in the usual way and the usual number of hours at the Policyholder's normal place of business or a site where the Policyholder's business requires You to travel.

You are considered Actively at Work on any day that is not Your regular scheduled work day (e.g., you are on vacation or holiday) as long as You were Actively at Work on Your immediately preceding scheduled work day.

Annual Enrollment Period means a date determined by the Policyholder on a yearly basis.

Certificate means this document, which provides a summary of the insurance benefits provided, to whom and how benefits are payable and exclusions and limitations that apply to coverage.

Change in Family Status means one of the following events:

- (a) You get married or enter into a legal relationship recognized as a spouse;
- (b) You and Your spouse divorce or legally terminate Your relationship;
- (c) Your child is born or You adopt, You receive a step child or become the legal guardian of a child;
- (d) Your spouse dies;
- (e) Your child is no longer a Dependent Child or dies;
- (f) Your spouse is no longer employed, which results in a loss of accident insurance sponsored by the Spouse's employer; or
- (g) You have a change in classification from part-time to full-time or from full-time to part-time.

Child Care Services means a child supervision services facility which:

- (a) is operated in a private home, school or other facility;
- (b) provides, and makes a charge for, the care of children; and
- (c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Child Care Services includes child care provided in the Primary Insured's or Spouse's home by a licensed child care provider, if such licensing is required by the state or jurisdiction in which it is located. If such licensing is not required, care in the home must be provided by an individual who offers professional child care services for a fee.

Child Care Services will not include child care which is provided by a Family Member of the child receiving the care.

Chip Fracture means an Injury where small fragments of bone are chipped from the bones main structure. These are also known as avulsion fractures.

Coma means complete unconsciousness with inability to respond to external or internal stimuli for a continuous period of at least 168 hours. The diagnosis of a Coma must be made by a Physician.

Common Carrier means commercial airplanes, helicopters, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis, privately chartered vehicles and the personal vehicles of a Covered Person are not Common Carriers.

Concussion means a traumatic brain injury resulting in immediate and transient alteration in brain function, including alteration of mental status and level of consciousness.

Confined or Confinement means being an Inpatient in a medical facility for a period of at least 1 day due to an Injury sustained in an Accident.

Confined Elsewhere means You are unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Covered Person means the Primary Insured and all Dependents.

Day Care or Day Care Program means a program of child care which:

- (a) is operated in a private home, school or other facility;
- (b) provides, and makes a charge for, the care of children; and
- (c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Day Care does not include care which is provided by a Family Member of the child receiving the care.

Dependent or Dependents means Your Dependent Child(ren) and/or Spouse covered by the Policy and this Certificate.

Dependent Child(ren) means Your or Your Spouse's natural children, step-children, legally adopted children, children placed into Your custody for adoption or children for whom You are ordered by a court or administrative order to provide coverage regardless of whether You are the custodial or non-custodial parent who are under 26 years of age.

If an unmarried child is age 26 or older and is:

- (a) incapable of self-sustaining employment because of a mental or physical handicap;
- (b) chiefly dependent on You for financial support;

and You have provided proof of his/her disability upon Our request, that child will continue to be a Dependent Child for as long as these conditions exist.

Coverage for a dependent child may be continued to age 30 if the unmarried child (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge and who qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code.

Dislocation means a completely separated joint.

- (a) open reduction of Dislocation means a surgical procedure.
- (b) closed reduction of Dislocation means a non-surgical procedure.

Dismemberment means the total and irrevocable loss of any of the losses referenced in the Benefit Schedule.

Emergency Room means a specified area within a Hospital that is designated for the emergency care of accidental injuries. This area must:

- (a) be staffed and equipped to handle trauma;
- (b) be supervised and provide treatment by Physicians; and
- (c) provide 24 hours a day service by registered graduate nurses (RNs).

Extended Care Facility means a place which:

- (a) is licensed by the state in which it is located;
- (b) provides nursing home care on an inpatient basis under the supervision of a Physician;
- (c) has nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN), or licensed practical nurse (LPN);
- (d) keeps a daily medical record of each patient; and
- (e) is either a freestanding facility or a ward, wing, or swing bed of a Hospital or other institution.

Family Member means the Covered Person's parents, spouse, domestic partner, children, siblings, grandparent, aunt, uncle, first cousin, nephew or niece. This includes adopted, in-law and step-relatives.

Follow-Up Treatment means consultation, care or services provided by a Physician for Injuries incurred from an Accident. Follow-Up Treatment must occur after initial treatment by a Physician or in an Emergency Room for Injuries due to the same Accident.

Fracture means a broken bone which can be seen by x-ray.

- (a) open reduction of fracture means a surgical procedure.
- (b) closed reduction of fracture means a non-surgical procedure.

Home Health Care means the provision of continued care and treatment of a Covered Person in the home if:

- (a) the institutionalization of the Covered Person in a Hospital or related institution or skilled nursing facility would otherwise have been required if Home Health Care were not provided; and
- (b) the plan of treatment covering the Home Health Care service is established and approved in writing by a Physician.

Home Office means Our office at One Hartford Plaza, Hartford, Connecticut 06155.

Hospital means an institution:

- (a) licensed to operate as a Hospital pursuant to law;
- (b) primarily and continuously engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
- (c) providing twenty-four hour nursing service by or under the supervision of registered nurses.

Hospital does not include:

- (a) convalescent homes, or convalescent, rest or nursing facilities;
- (b) facilities affording primarily custodial, educational or rehabilitative care; or
- (c) facilities for the aged, drug addicts or alcoholics.

Injury or Injuries means bodily injury sustained by a Covered Person that is the direct result of an Accident, and is independent of disease or bodily infirmity.

Inpatient means treatment received by the Covered Person as a resident patient using and being charged for the room and board facilities of a Hospital.

Intensive Care Unit (ICU) means a specifically designated part of a Hospital called an intensive care unit as listed in the most current American Hospital Association Guide that:

- (a) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. An Intensive Care Unit includes a neonatal intensive care unit specializing in the care of ill or premature newborn infants;
- (b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- (c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis; and
- (e) has an assigned Physician on a full-time basis.

An Intensive Care Unit is not any of the following step-down units:

- (a) a progressive care unit;
- (b) an intermediate care unit;
- (c) a private monitored room;
- (d) sub-acute intensive care unit; or
- (e) an Observation Unit.

Laceration means a cut of at least 2 inches in length requiring sutures.

Medical Appliance means a walking boot that extends above the ankle, brace for the neck, back, knee or leg, cane, crutches, walker and wheelchair.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient surgery or treatment in the Emergency Room by a Physician and which:

- (a) is under the direct supervision of a Physician or registered nurse;
- (b) is staffed by nurses assigned specifically to that unit; and
- (c) provides care seven days per week, 24 hours per day.

Off the Job Coverage means coverage is provided under the Policy for Injuries resulting from an Accident that occurs while the Primary Insured is not working for pay or profit.

On the Job Coverage means coverage is provided under the Policy only for Injuries resulting from an Accident that occurs while the Primary Insured is working for pay or profit.

Outpatient means treatment received by the Covered Person at a Hospital or licensed ambulatory care facility and there is no charge for room and board.

Paralysis means an Injury to the brain or spinal cord that results in loss of use or loss of movement of multiple limbs (arms and/or legs).

Paraplegia means the complete and irreversible Paralysis of both legs.

Physician means a person who is:

- (a) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art that We recognize or are required by law to recognize;
- (b) licensed to practice in the jurisdiction where care is being given;
- (c) operating within the scope of his or her license; and
- (d) not a Family Member.

Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page, this Certificate and all other riders, amendments and endorsements that make up the contract of insurance.

Primary Insured refers to the Active Employee.

Quadriplegia means the complete and irreversible Paralysis of both arms and both legs.

Qualifying Event for You means any termination of coverage under the Policy, prior to age 80, in accordance with the Termination provision for any reason, except:

- (a) non-payment of premium; or
- (b) termination of the group policy.

Qualifying Event for Your Spouse is Your death or divorce while You are insured under the Policy. The Qualifying Event must occur prior to Your Spouse's attainment of age 80.

Dependent Child(ren) coverage is continued if You or Your Spouse elect to continue coverage due to Your or Your Spouse's own Qualifying Event.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The rehabilitation unit may be part of a Hospital or a freestanding facility.

A rehabilitation unit is not:

- (a) a nursing home;
- (b) an Extended Care Facility;
- (c) a skilled nursing facility;
- (d) a rest home or home for the aged;
- (e) a hospice care facility;
- (f) a place for alcoholics or drug addicts; or
- (g) an assisted living facility.

Second Degree Burn means a burn in which damage penetrates into some of the underlying layers of skin.

Spouse means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.

Spouse will include those who have entered into a civil union under The Religious Freedom Protection Act and Civil Union Act. 750 ILCS 75/, which allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

Third Degree Burn means a burn which extends to all layers of skin.

Urgent Care Facility means a facility or place other than a Physician's office, Hospital, or an Emergency Room that provides emergency or urgent care and treatment to injured people. Such facility may be a 24-hour clinic.

Waiting Period means the length of time You must be a member in an Eligible Class before You can apply for insurance. The Waiting Period is shown in the Benefit Schedule.

We, Us, Our means Hartford Life and Accident Insurance Company.

You or Your refers to the Primary Insured.

ELIGIBILITY AND EFFECTIVE DATES

Primary Insured's Eligibility for Coverage: You will become eligible for coverage on the latest of:

- (a) the Policy Effective Date;
- (b) the date You become a member of an Eligible Class for Coverage; or
- (c) the date You complete the Waiting Period.

Dependent Eligibility for Coverage: Your Dependent(s) will become eligible for coverage on the later of:

- (a) the date You become insured for employee coverage; or
- (b) the date You acquire Your first Dependent.

You may not cover Your Dependent if such Dependent is covered as an Active Employee under the Policy. No person can be insured as a Dependent of more than one Active Employee under the Policy.

Enrollment:

To enroll, You must:

- (a) complete and sign a group insurance enrollment form for Your coverage and Your Dependent's coverage within 31 days of the date You are eligible for coverage; and
- (b) deliver it to the Policyholder.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under the Policy, and later choose to enroll, You may only enroll for Your coverage and/or Your Dependent's coverage:

- (a) during an Annual Enrollment Period designated by the Policyholder; or
- (b) within 31 days of the date You have a Change in Family Status.

Primary Insured's Coverage Effective Date:

Your coverage will start on the later to occur of:

- (a) the first of the month on or next following the date You become eligible;
- (b) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
- (c) the first of the month on or next following the date You enroll, if You do so within 31 days from the date You are eligible.

All effective dates of coverage are subject to the Deferred Coverage Effective Date provision.

Deferred Coverage Effective Date: Your Effective Date for Coverage will be delayed if You are not Actively at Work due to physical or mental condition on the Effective Date for Coverage shown on the Benefit Schedule. Coverage will become effective on the date You are Actively at Work.

Dependent Effective Date: Coverage will start on the latest to occur of:

- (a) the first of the month on or next following the date Your Dependent becomes eligible for Dependent coverage, if You have enrolled on or before that date; or
- (b) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- (c) the first of the month on or next following the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

Deferred Coverage Effective Date for Dependents: If, on the date Your Dependent, is to become covered under the Policy:

- (a) on the Effective Date for Coverage; or
- (b) for increased benefits; or
- (c) for a new benefit; and

he or she is:

- (a) confined; or
- (b) Confined Elsewhere;

such coverage will not start until he or she:

- (a) is discharged from the Hospital; or
- (b) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender in good health, for at least 15 consecutive days.

Newlywed Coverage: If You marry while covered under the Policy, Your Spouse shall automatically become covered under the Policy for 31 days after the date of marriage. Benefits and amounts will be the minimum amount for those We are providing for Spouse coverage under the Policy at that time.

Coverage of Your Spouse will cease after 31 days from the date of marriage unless You:

- (a) request in writing that coverage for Your Spouse be continued; and
- (b) pay the additional required premium.

Newborn and Newly Adopted Child Coverage: If, while covered under the Policy, You:

- (a) have a newborn child; or
- (b) adopt or receive a stepchild;

the child will become covered under the Policy for 31 days after the date of birth or placement with You. Benefits and amounts will be the minimum amount for those We are providing for Dependent Child(ren) under the Policy at that time.

Coverage of the new child will cease after 31 days from the date of birth or financial dependence unless You:

- (a) request in writing that coverage for Your child be continued; and
- (b) pay the additional required premium.

TERMINATION OF INSURANCE

Termination of Primary Insured's Coverage: Your coverage will end on the earliest of the following:

- (a) the date the Policy terminates;
- (b) the last day of the month following the date You are no longer in a class eligible for coverage, or the Policy no longer covers Your class;
- (c) the date the required premium is due but not paid, subject to the individual grace period;
- (d) the last day of the month following the date You request We terminate Your coverage;
- (e) the last day of the month following the date the Policyholder terminates Your employment; or
- (f) the last day of the month following the date You are no longer Actively at Work;

unless continued in accordance with one of the Continuation Provisions.

Termination of Dependent Coverage: Coverage for Your Dependent(s) will end on the earliest to occur of:

- (a) the date Your coverage ends;
- (b) the date the required premium is due but not paid, subject to the individual grace period;
- (c) the last day of the month following the date You are no longer eligible for Dependent coverage;
- (d) the last day of the month following the date We or the Policyholder terminate Dependent coverage;
- (e) the last day of the month following the date You request We terminate Dependent coverage;
- (f) the last day of the month following the date the child no longer meets the definition of Dependent Child; or
- (g) the last day of the month following the date that You and Your Spouse are no longer married;

unless continued in accordance with one of the Continuation Provisions.

CONTINUATION PROVISIONS

Continuation: Coverage may be continued, at the Policyholder's option beyond a date shown in the Termination provision, if the Policyholder provides a plan of continuation which applies to all employees the same way.

Coverage for Your Dependents will continue if Your coverage is continued.

The amount of continued coverage applicable to You or Your Dependent will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- (a) is subject to any reductions in the Policy;
- (b) is subject to payment of premium;
- (c) may be continued up to the maximum time shown in the provisions; and
- (d) terminates if the Policy terminates.

The amount of insurance will not increase while coverage is being continued. The Continuation Provisions shown below may not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents 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 (including Dependent coverage) may be continued for 3 months following the last day of 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 or Your Dependents enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent coverage) may be continued for up to 12 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Policyholder due to lack of work, all of Your coverage (including Dependent coverage) may be continued for 3 months following the last day of the month in which the lay off commenced. If the lay off becomes permanent, this continuation will cease immediately.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, Your coverage (including Dependent coverage) may be continued:

- (a) for a period of 12 months from the date You were last Actively at Work; or
- (b) 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 months.

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) (including Dependent coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

VOLUNTARY ACCIDENT BENEFITS

Accident Follow-Up Benefit: We will pay the Accident Follow-Up Benefit Amount shown in the Benefit Schedule for each day a Covered Person receives Follow-Up Treatment for Injuries sustained in an Accident. Treatment must be recommended or advised by a Physician. Follow-Up Treatment must be received within 90 days of the Accident. Follow-Up Treatment does not include routine examinations or preventative testing. This Accident Follow-Up Benefit is subject to a maximum of 3 visits per Accident per Covered Person.

Acupuncture Benefit: We will pay the Acupuncture Benefit Amount shown in the Benefit Schedule if a Covered Person receives acupuncture services for treatment of an Injury sustained in an Accident. Acupuncture must be provided by a practitioner licensed as required in the state where care is provided. Acupuncture must begin within 30 days after the date of the Accident and be completed within one year of the date of Accident. No more than 10 Acupuncture Benefits are payable per Accident per Covered Person regardless of the number of acupuncture treatments received.

Ambulance (Air) Benefit: We will pay the Ambulance (Air) Benefit Amount shown in the Benefit Schedule for a licensed professional air ambulance company to transport a Covered Person to or from a Hospital, or between medical facilities for treatment of Injuries received in an Accident. The air ambulance must provide the transportation services to the Covered

Person within 72 hours after the date of the Accident. One Ambulance (Air) Benefit is payable per Accident per Covered Person.

Ambulance (Ground) Benefit: We will pay the Ambulance (Ground) Benefit Amount shown in the Benefit Schedule for a licensed professional ambulance company to transport a Covered Person by ground, to or from a Hospital or between medical facilities for treatment of Injuries received in an Accident. The ambulance must provide transportation services to the Covered Person within 90 days after the date of the Accident. One Ambulance (Ground) Benefit is payable per Accident per Covered Person.

Blood/Plasma/Platelet Benefit: We will pay the Blood/Plasma/Platelet Benefit Amount shown in the Benefit Schedule if, due to an Injury sustained in an Accident, a Covered Person requires a transfusion, administration, cross matching, typing and processing of blood, plasma or platelets. The blood, plasma or platelet transfusion must be administered within 90 days of the Accident. Only one Blood/Plasma/Platelet Benefit is payable per Accident per Covered Person.

Child Care Benefit: We will pay the Child Care Benefit Amount shown in the Benefit Schedule if the Primary Insured or Spouse is confined in a Hospital due to an Accident and requires Child Care Services for children under age 16. The Benefit Amount is available for each child receiving care and shall not exceed the Maximum Daily Amount shown in the Benefit Schedule. No more than 30 days of Child Care Services are payable per Accident regardless of the number of days child care is needed. We must receive satisfactory proof that the Dependent Child is enrolled in a Day Care Program.

Chiropractic Care Benefit: We will pay the Chiropractic Care Benefit Amount shown in the Benefit Schedule if a Covered Person receives chiropractic treatment for an Injury sustained in an Accident. The chiropractor must be licensed if required in the state where care is provided. Chiropractic Care must begin within 30 days after the date of the Accident and be completed within one year of the date of Accident. No more than 10 Chiropractic Care Benefits are payable per Accident per Covered Person regardless of the number of chiropractic treatments received.

Daily Hospital Confinement Benefit: We will pay the Daily Hospital Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person was Confined in a Hospital due to an Injury received in an Accident. Confinement must begin within 90 days of the Accident and last at least 20 hours. The Daily Hospital Confinement Benefit is subject to a lifetime maximum of 365 days per Covered Person. This maximum includes all days a Covered Person is Confined in a Hospital, including days in an Intensive Care Unit of a Hospital. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Accident. The Daily Hospital Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily Hospital Confinement Benefit and the Daily Intensive Care Unit Confinement Benefit concurrently for the same Covered Person. We will also not pay this Daily Hospital Confinement Benefit and the Rehabilitation Facility Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Daily ICU Confinement Benefit: Unless the Covered Person has reached his or her lifetime maximum Daily Hospital Confinement Benefits, We will pay the Daily ICU Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in an Intensive Care Unit due to an Injury received within 30 days of an Accident. If a Covered Person is Confined in an ICU for more than 30 days, the Daily Hospital Confinement Benefit will begin on the 31st day, provided the Covered Person has not reached his or lifetime maximum for Daily Hospital Confinement benefits. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Accident. The Daily ICU Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily ICU Confinement Benefit and the Daily Hospital Confinement Benefit concurrently for the same Covered Person.

Diagnostic Exam Benefit: We will pay the Diagnostic Exam Benefit Amount shown in the Benefit Schedule if a Covered Person requires one of the following diagnostic examinations to determine the extent of an Injury sustained in an Accident:

- (a) Computerized Axial Tomography (CAT);
- (b) Computed Tomographies (CT Scan);
- (c) Magnetic Resonance Imagings (MRIs); or
- (d) Electroencephalogram (EEG).

The diagnostic exam must be scheduled within 90 days after the date of the Accident. Only 1 Diagnostic Exam Benefit Amount is payable per Accident per Covered Person regardless of the number of diagnostic examinations received.

Emergency Dental Benefit (extraction and crown): We will pay the Emergency Dental Benefit Amount shown in the Benefit Schedule if a Covered Person requires the following dental work as a result of an Injury sustained in an Accident:

- (a) repair of a broken sound, natural tooth with a crown; or
- (b) extraction of a broken sound, natural tooth.

The dental work must occur within 90 days after the Accident. Only one Emergency Dental Benefit Amount is payable per Accident per Covered Person regardless of the number of teeth involved.

Emergency Room Benefit: We will pay the Emergency Room Benefit Amount shown in the Benefit Schedule if a Covered Person requires examination and treatment by a Physician in an Emergency Room as the direct result of an Injury sustained in an Accident. The Emergency Room examination and treatment must occur within 72 hours after the date of the Accident. No more than 1 Emergency Room Benefits will be payable per Accident per Covered Person.

Hospital Admission Benefit: We will pay the Hospital Admission Benefit Amount shown in the Benefit Schedule if, as a result of an Injury received in an Accident, a Covered Person is admitted to a Hospital. Admission to the Hospital must occur within 90 days of the Accident. The Hospital Admission Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit.

Initial Physician's Visit Benefit: We will pay the Initial Physician's Visit Benefit Amount if a Covered Person receives initial treatment by a Physician in a Physician's office as the result of an Injury sustained in an Accident. The treatment must be given within 90 days after the Accident. Services for routine examinations or preventative testing are not included in this benefit.

Lodging Benefit: We will pay the Lodging Benefit Amount shown in the Benefit Schedule for a companion to accompany the Covered Person while the Covered Person is Confined in a Hospital due to an Injury sustained in an Accident. The Covered Person must be Confined in a Hospital located more than 100 miles from the Covered Person's residence. This benefit will be payable for one room if the companion incurs a charge for staying in a hotel or a motel while the Covered Person is Confined. This Lodging Benefit is subject to a lifetime maximum of 30 days per Covered Person.

Medical Appliance Benefit: We will pay the Medical Appliance Benefit Amount shown in the Benefit Schedule if, due to an Injury sustained in an Accident, a Covered Person requires a Medical Appliance as an aid in personal locomotion or mobility. The Medical Appliance must be prescribed by a Physician. Use of the Medical Appliance must begin within 90 days of the Accident. Only one Medical Appliance Benefit is payable per Accident per Covered Person.

Physical Therapy Benefit: We will pay the Physical Therapy Benefit Amount shown in the Benefit Schedule for each day a Covered Person requires physical therapy treatment for an Injury received in an Accident. Physical therapy must begin within 90 days of the Accident or within 90 days of the date a Physician prescribes physical therapy following surgery or other medical treatment for Injury sustained in an Accident. The Physical Therapy Benefit is subject to a maximum of 10 days per Covered Person per Accident. Physical therapy must be prescribed by a Physician and rendered by a licensed physical therapist in an office or Hospital on an Inpatient or Outpatient basis.

Rehabilitation Facility Benefit: We will pay the Rehabilitation Facility Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in a Rehabilitation Unit for physical, occupational or speech therapy treatment for an Injury received in an Accident. Confinement must begin within 90 days of the Accident and be preceded by Confinement in a Hospital. The Rehabilitation Facility Benefit is subject to a lifetime maximum of 15 days per Covered Person. We will pay benefits for only one period of Rehabilitation Facility Confinement at a time even if it is caused by more than one Accident. We will not pay this Rehabilitation Facility Benefit and the Daily Hospital Confinement Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Transportation Benefit: We will pay the Transportation Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person must travel more than 100 miles from his or her residence to a receive special treatment or be Confined in a Hospital. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to 3 round trips per Covered Person per Accident. This benefit is not payable for transportation by ambulance (air or ground).

Urgent Care Benefit: We will pay an Urgent Care Benefit if a Covered Person requires treatment or care in an Urgent Care Facility due to an Injury sustained in an Accident. The Treatment must occur within 72 hours after the date of the Accident. No more than 1 Urgent Care Benefits will be payable per Accident per Covered Person.

X-Ray Benefit: We will pay the X-Ray Benefit Amount shown in the Benefit Schedule if a Covered Person requires an x-ray as a result of an Injury sustained in an Accident. The x-ray must be prescribed by a Physician and performed in Physician's office or Hospital on an Inpatient or Outpatient basis. The x-ray must be performed within 90 days after the date of the Accident. Only one X-ray Benefit Amount is payable per Accident per Covered Person regardless of the number of x-rays received.

Dislocations Benefit (open reduction, closed reduction and incomplete): If a Covered Person sustains a Dislocation as a result of an Accident, We will pay the Dislocation Benefit Amount shown in the Benefit Schedule.

The Dislocation must be diagnosed and corrected via an open (surgical) or closed (non-surgical) reduction under anesthesia by a Physician.

If a Physician diagnoses the Dislocation as incomplete (the joint is not completely separated), or the Dislocation requires treatment without anesthesia by a Physician, We will pay 25% of the Dislocation Benefit shown in the Benefit Schedule for a closed reduction a Dislocation for that joint.

If a Covered Person sustains one or more Fractures and Dislocations due to the same Accident, We will pay both the Fractures Benefit and the Dislocations Benefit. We will pay no more than two times the amount for the bone or joint involved that has the highest benefit amount.

This benefit is payable once per joint, per Covered Person. Further Dislocations of the same joint will not be covered under the Policy after a Dislocation Benefit has already been paid for that joint.

Fractures Benefit (open reduction, closed reduction and Chip Fractures): We will pay the Fractures Benefit Amount shown in the Benefit Schedule for a Fracture sustained in an Accident. If a Covered Person sustains more than one Fracture due to the same Accident, we will pay the benefits for all Fractures to a maximum of two times the amount shown in the Benefit Schedule for the bone involved with the highest benefit amount.

If the Covered Person is diagnosed by a Physician as having a Chip Fracture, we will pay 25% of the benefit shown in the Benefit Schedule for a closed reduction of the bone.

If a Covered Person sustains a Fracture and a Dislocation due to the same Accident, we will pay both benefits. We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

The Fracture must be diagnosed by a Physician within 90 days of the Accident and must require open (surgical) reduction or closed (non-surgical) reduction by a Physician.

Abdominal/Thoracic Surgery Benefit: We will pay the Abdominal/Thoracic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of an Injury sustained in an Accident, a Covered Person undergoes open abdominal or thoracic surgery to repair internal Injuries. The surgery must occur within 90 days of the Accident to repair Injury. Hernia repair is not covered under this benefit. Only one Abdominal/Thoracic Surgery Benefit is payable per Accident per Covered Person. Either the Abdominal/Thoracic Surgery Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Arthroscopic Surgery Benefit: We will pay the Arthroscopic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of Accident, a Covered Person undergoes arthroscopic surgery. The surgery must occur within 90 days of the Accident to repair an Injury sustained in the Accident. Hernia repair is not covered under this benefit. Only one Arthroscopic Surgery Benefit is payable per Accident per Covered Person. We will pay either the Arthroscopic Surgery Benefit or the greater of the following benefits for the same Accident:

- (a) Knee Cartilage Benefit;
- (b) Ruptured Disc Benefit;
- (c) Abdominal/Thoracic Surgery Benefit; or
- (d) Tendon/Ligament/Rotator Cuff Benefit.

Burn Benefit: We will pay the Burn Benefit Amount shown in the Benefit Schedule if, as a result of an Injury sustained in an Accident, a Covered Person sustains either:

- (a) Third Degree Burns covering at least 18 square inches of the Covered Person's body; or
- (b) Second Degree Burns covering at least 34% of the Covered Person's body.

The Covered Person must be treated by a Physician within 72 hours after the date of the Accident. Only one Burn Benefit is payable per Accident per Covered Person, however if burns are in multiple degrees, then the highest benefit will be paid.

Skin Graft Benefit: We will pay the Skin Graft Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person receives a skin graft for a Third Degree Burn for which a benefit was received under the Burn Benefit. Only one Skin Graft Benefit is payable per Accident per Covered Person.

Concussion Benefit: We will pay the Concussion Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person is diagnosed with a Concussion. The Concussion must be diagnosed or treated by a Physician within 72 hours of Accident. No more than 3 Concussions will be covered per year per Covered Person.

Eye Injury Benefit: We will pay the Eye Injury Benefit Amount shown in the Benefit Schedule if a Covered Person sustains an Injury sustained in an Accident to the eye. The Injury must require surgery or removal of a foreign object by a Physician within 90 days of the Accident. Only one Eye Injury Benefit is payable per Accident per Covered Person.

Hernia Benefit: We will pay the Hernia Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a hernia. The hernia must be diagnosed by a Physician within 30 days of the Accident and must be repaired by surgery within one year from the date of the Accident.

Joint Replacement Benefit: We will pay the Joint Replacement Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains an Injury requiring a knee, hip or shoulder joint replacement. The joint replacement must be diagnosed within 90 days of the Accident and surgery must occur within one year of the Accident. Only one Joint Replacement Benefit is payable per Accident per Covered Person.

Knee Cartilage Benefit: We will pay the Knee Cartilage (with repair or without repair) Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a torn knee cartilage (meniscus). Treatment must be first provided by a Physician within 60 days of the Accident. If surgery is required, the Covered Person must undergo surgery within 12 month(s) of the Accident. Only one Knee Cartilage Benefit is payable per Accident per Covered Person. Either the Knee Cartilage Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Lacerations Benefit: We will pay the Lacerations Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a Laceration. The Laceration must be repaired by a Physician within 72 hours of the Accident. The benefit payable will be based on the total length of all Lacerations received in any one Accident which requires repair. Only one Lacerations Benefit is payable per Accident per Covered Person. If a Covered Person sustains a Laceration that later results in loss or Dismemberment, We will subtract the amount paid under the Lacerations Benefit from the Accidental Dismemberment Benefit.

Ruptured Disc Benefit: We will pay the Ruptured Disc Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a ruptured or herniated disc in the spine that must be repaired through surgery. The Covered Person must receive treatment from a Physician for the ruptured or herniated disc within 60 days of the Accident and surgery must be performed within one year of the Accident. Only one Ruptured Disc Benefit is payable per Accident per Covered Person regardless of the number of surgeries needed. Either the Ruptured Disc Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Tendon/Ligament/Rotator Cuff Benefit: We will pay the Tendon/Ligament/Rotator Cuff Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person receives a torn, ruptured or severed tendon, ligament or rotator cuff. The Injury must be treated by a Physician within 90 days of the Accident and be repaired by surgery within one year. Only one Tendon/Ligament/Rotator Cuff benefit is payable per Accident per Covered Person. Either the Tendon/Ligament/Rotator Cuff Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Accidental Death Benefit: If a Covered Person dies as a direct result of an Injury sustained in an Accident, We will pay the Accidental Death Benefit Amount shown in the Benefit Schedule. Death must occur within 90 days of the Accident. This benefit is not payable if We pay the Accidental Death – Common Carrier Benefit for the same Covered Person.

Accidental Death – Common Carrier Benefit: If a Covered Person dies as a direct result of an Injury sustained in an Accident while a fare paying passenger on a Common Carrier, We will pay the Accidental Death – Common Carrier Benefit Amount shown in the Benefit Schedule. Death must occur within 90 days of the Accident. This benefit is not payable if We pay the Accidental Death Benefit.

Accidental Dismemberment Benefit: If a Covered Person sustains dismemberment as a direct result of an Injury sustained in an Accident, We will pay the Accidental Dismemberment Benefit Amount shown in the Benefit Schedule. Dismemberment must occur within 90 days of the Accident.

Coma Benefit: We will pay the Coma Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person is diagnosed with a Coma. The Coma must be diagnosed or treated by a Physician within 90 days of the Accident. Only one Coma Benefit is payable per Accident per Covered Person.

Home Health Care Benefit: We will pay the Home Health Care Benefit Amount shown in the Benefit Schedule for each day a Covered Person receives Home Health Care as a result of an Accident. The Home Health Care Benefit is payable for the lesser of 30 days or the number of days the Covered Person is receiving Home Health Care. The Home Health Care Benefit is payable in addition to the Daily Hospital Confinement Benefit or the Daily ICU Confinement Benefit.

Paralysis Benefit: We will pay the Paralysis Benefit Amount shown in the Benefit Schedule if, as a result of an Injury sustained in an Accident, a Covered Person is paralyzed and sustains Paraplegia or Quadriplegia. The Paralysis must occur within 90 days of the Accident, must have lasted at least 30 days, and must be expected to be permanent. Paralysis must be diagnosed by a Physician and based on evidence that the Injury sustained in the Accident caused the Paralysis.

Prosthesis Benefit: We will pay the Prosthesis Benefit Amount shown in the Benefit Schedule if, due to an Injury in an Accident, a Covered Person:

- (a) loses a hand, foot, arm, leg, eye; and
- (b) requires a prosthetic device, artificial limb or eye, as prescribed by a Physician.

The prosthetic device/artificial limb or eye must be received within one year after the date of the Accident. This benefit is not payable for joint replacement such as an artificial hip or knee. Only one Prosthesis Benefit is payable per Accident per Covered Person.

EXCLUSIONS

Exclusions: No benefits are payable under this Certificate for an Injury that results from or is caused by:

- (a) war or act of war, whether declared or undeclared;
- (b) the Covered Person's participation in a felony, riot or insurrection;
- (c) the Covered Person's service in the armed forces or units auxiliary to it;
- (d) the Covered Person's taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
- (e) a Covered Person's bacterial infections, except infections which result from an accidental Injury or infection which results from accidental, involuntary or unintentional ingestion of a contaminated substance;
- (f) a Covered Person's participation in bungee jumping or hang gliding;
- (g) a Covered Person's participation or competition in semi-professional or professional sports;
- (h) cosmetic surgery or any other elective procedure that is not medically necessary;
- (i) a Covered Person being intoxicated as defined by the jurisdiction in which the cause of loss was incurred;
- (j) while the Covered Person is on any aircraft:
 - 1) as a pilot, crewmember or student pilot;
 - 2) as a flight instructor or examiner;
 - 3) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under the Policy;
 - 4) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
- (k) operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven. This exclusion does not apply where the Covered Person is riding as a fare-paying passenger on a regularly scheduled commercial airline or as a passenger for transportation only and not as a pilot or crew member; or
- (l) riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

CLAIM PROVISIONS

Notice of Claim: Written Notice of Claim must be given to Us within 20 days after the start of any loss covered by this Certificate, or as soon as is reasonably possible. Notice given by or on behalf of a Covered Person to Us at The Hartford

Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

Claim Forms: When We receive written Notice of Claim, We will send claim forms. If the claimant does not receive the forms within 15 days after written notice of claim is sent, Proof of Loss may be sent to Us without waiting to receive the claim forms.

Proof of Loss: The claimant must send Us written Proof of Loss at Our Home Office. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of Loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately after Our receipt of due written Proof of Loss. If payment is not made within 30 days following Our receipt of satisfactory proof of claim, then You are entitled to interest at the rate of 9% per annum from the 30th day after receipt of such proof to the date of payment.

Payment of Claims: Death benefits for the Primary Insured will be payable to the beneficiary that he/she designated. If no beneficiary is designated or living, the death benefit will be payable to the Primary Insured's estate. Any other accrued benefits unpaid at the Primary Insured's death may, at Our option, be paid either to the beneficiary or to the Primary Insured's estate. All other indemnities will be payable to the Primary Insured.

If any benefit is payable to the Primary Insured's estate, or to an individual who is a minor or otherwise not competent to give a valid release, We may pay such benefit, up to an amount not exceeding \$1,000, to any person related to the Primary Insured by blood or marriage or the beneficiary, if We determine the person to be equitably entitled the benefit. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of the payment.

We will pay the benefits for loss of life upon the death of the any Dependents of the Primary Insured to the Primary Insured, if living. Otherwise, it will be paid, at Our option, to the Primary Insured's surviving spouse or the executor or administrator of his/her estate.

Physical Examinations and Autopsy: We at Our own expense, have the right and opportunity to examine a Covered Person 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 Denial: If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

- (a) give the specific reason(s) for the denial;
- (b) make specific reference to the Policy provisions on which the denial is based;
- (c) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- (d) provide an explanation of the review procedure.

Claim Appeal: On any claim, a claimant may appeal to Us for a full and fair review. To do so We:

- (a) must receive a written application for review within:
 - 1) 180 days of receipt of claim denial if the claim requires Us to make a determination of an Injury; or
 - 2) 60 days of receipt of claim denial if the claim does not require Us to make a determination of an Injury; and
- (b) upon request We will provide copies of all documents records, and other information relevant to the claimant's claim; and
- (c) We will consider any additional written comments, documents records and other information relating to the claim.

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

Overpayment Recovery: We have the right to recover from the Covered Person any amount that We determine to be an overpayment. The Covered Person has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, the Covered Person must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

- (a) recover such overpayments from:
 - 1) the Covered Person;
 - 2) any other person to or for whom payment was made; and

- 3) the Covered Person's estate;
- (b) reduce or offset against any future benefits payable to the Covered Person or his/her survivors until full reimbursement is made;
- (c) refer the Covered Person's unpaid balance to a collection agency; and
- (d) pursue and enforce all legal and equitable rights in court.

PORTABILITY

Portability Benefit: Portability allows You or Your Dependent(s) to continue coverage under a group portability policy when coverage ends under this Certificate due to a Qualifying Event. If You or Your Dependent(s) qualify for and elect portability as stated in this provision, coverage will continue under a group portability policy subject to the Exclusions provision, without interruption with respect to all benefits and periods as stated in the Policy.

The terms, conditions and premium rates of the portability coverage will be governed by the portability policy. Your and Your Dependent(s) coverage under the portability policy will not continue past the Primary Insured's attainment of age 80.

If the Qualifying Event is Your death or divorce, Your Dependents coverage under the portability policy will not continue past his or her attainment of age 80.

Electing Portability: You may elect Portability if Your Accident insurance ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your coverage ends due to Your own Qualifying Event. The Policy must still be in force for Portability to be available.

Your Spouse may elect Portability for him/her and Your Dependent Child(ren) if Your coverage under the Policy ends due to Your death or divorce, if Your Spouse is under age 80 at the time of the Qualifying Event.

To elect Portability, You or Your Spouse if coverage ends due to Your death or divorce must:

- (a) complete a portability application; and
- (b) submit the application to Us, with the required premium.

This must be received within 31 days after accident insurance terminates. However, Portability requests will not be accepted if they are received more than 91 days after accident insurance terminates.

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

- (a) issued without evidence of insurability;
- (b) issued on one of the forms then being issued by Us for Portability; and
- (c) effective on the day following the date Your or Your Spouse's coverage ends, such that there is no interruption in coverage between the Policy and the portability policy.

Limitations On Portability: You may elect to continue 100% of each Covered Person's amount of insurance in force under the Policy on the date Your insurance terminates.

Your Spouse may apply for portable insurance in an amount up to 100% of the amount of Spouse Insurance and Dependent Child(ren) Insurance in force under the Policy on the date of Your death or divorce.

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to divorce.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to Your own Qualifying Event.

GENERAL PROVISIONS

Entire Contract Changes: The Policy, the Application(s), this Certificate, any individual enrollment forms, riders, endorsements and any other attached papers make up the entire contract of insurance between the Policyholder and Us.

No change in the Policy or this Certificate will be valid until approved by an officer of Ours. The approval must be in writing and must be attached to or noted on the Policy. In the event of the death or incapacity of the Covered Person, no beneficiary or personal representative of the Covered Person has authority to change the Policy or this Certificate or to waive any provisions.

Statements: In the absence of fraud, all statements made by the Policyholder or any Covered Person will be considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or his or her beneficiary or personal representative.

Time Limit on Certain Defenses: After a Covered Person has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period.

Legal Actions: No legal action may start:

- (a) until 60 days after Proof of Loss has been given;
- (b) more than 3 years after the time Proof of Loss is required to be given.

Change of Beneficiary: You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Policyholder. Only satisfactory forms sent to the Policyholder prior to Your death will be accepted.

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 Policyholder.

In no event may a beneficiary be changed by a Power of Attorney.

Misstatement of Age: If the age of any Covered Person has been misstated, all amounts payable shall be such as the premium paid would have purchased at the correct age.

Insurance Fraud:

Insurance Fraud occurs when You, Your Dependents and/or the Policyholder 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, Your Dependents and/or the Policyholder 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, Your Dependents and/or the Policyholder perpetrate insurance fraud.

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

- (a) the right to make any contributions required to keep the insurance in force;
- (b) the right to convert; and
- (c) the right to name and change a beneficiary.

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

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

We and the Policyholder assume no responsibility:

- (a) for the validity or effect of any assignment; or
- (b) 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.

Unpaid Premium: Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, conflicts with any applicable law is amended to meet the minimum requirements of the law.

Time Periods: All periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

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

Amendatory Rider



HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

This rider forms a part of a Certificate given in connection with the Policy.

This rider becomes effective on July 1, 2023.

With respect to All Part-time Active Employees, Your Certificate is amended as follows:

1. The following **Health Screening** benefit shall be included under **Accident Benefits** in the **Benefit Schedule** section of Your Certificate:

Description of Benefit	Benefit Amount
Health Screening	\$50

2. The following **Additional Enrollment Event** definition shall be included in the **Definitions** section of Your Certificate:

Additional Enrollment Event means a period of time designated for enrollment under the Policy, other than an Annual Enrollment Period, as agreed to in writing by Our authorized representative in our Home Office.

3. The following **Health Screening Test** definition shall be included in the **Definitions** section of Your Certificate:

Health Screening Test means any of the following: abdominal aortic aneurysm ultrasound; blood test for triglycerides; bone marrow testing; bone density screening; breast ultrasound; CA 15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); carotid ultrasound; CEA (blood test for colon cancer); cervical cancer screening; chest X-Ray; colonoscopy; COVID-19 testing when performed by an appropriately licensed medical professional; CT angiography; ECG/EKG; double contrast barium enema; fasting blood glucose test; flexible sigmoidoscopy; hemoccult stool analysis; lipid panel; mammography; pap smear; PAD ultrasound; PSA (blood test for prostate cancer); serum cholesterol test (for HDL and LDL levels); SPEP (blood test for myeloma); stress test (on a bicycle or treadmill); or thermography. Any other generally medically accepted cancer-screening test is also included in this definition.

4. The following **Changes in Coverage** provision shall be included in the **Eligibility and Effective Dates** section of Your Certificate:

Changes in Coverage: An Employee may:

- (a) elect, increase, decrease, drop or otherwise change coverage during an Annual Enrollment Period or any Additional Enrollment Event; or
- (b) increase, decrease, drop or otherwise change coverage within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on:

- (a) the Policy anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
 - (b) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
 - (c) the date on which the change is requested following a Change in Family Status;
- subject to the Deferred Coverage Effective Date or Deferred Coverage Effective Date for Dependents provisions.

An initial period of coverage for a new Dependent may be available under the Newlywed Coverage or Newborn and Newly Adopted Child Coverage provisions.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the date of the request or change.

5. The following **Reinstatement of Insurance** section shall be included in Your Certificate following the **Termination of Insurance** section:

REINSTATEMENT OF INSURANCE

Reinstatement of Coverage: Coverage for an Employee and any previously insured Dependent(s) under the Policy may be reinstated after it ends if:

- (a) the Employee returns to an Eligible Class for Coverage within 12 months from the date coverage ended; and
- (b) reinstatement is requested within 31 days from his/her return to an Eligible Class for Coverage, if coverage requires an election under the Policy;

except for coverage that ended due to non-payment of premium or voluntary termination of coverage by an Employee.

We will credit any time the Employee and any Dependent(s) were previously insured under the Policy toward the satisfaction of the Waiting Period.

Reinstated coverage will become effective on the first of the month following the date on which the reinstatement is requested subject to the Deferred Coverage Effective Date or Deferred Coverage Effective Date for Dependents provisions.

Reinstated coverage is subject to all other terms and provisions of the Policy.

If coverage ended due to non-payment of premium or voluntary termination of coverage by an Employee, reinstatement is not available. The Employee may not re-enroll until the next Annual Enrollment Period or Additional Enrollment Event occurs.

Reinstatement is also not available for coverage that an Employee or any Dependent(s) continued under the Portability provision; unless such coverage is cancelled or surrendered.

6. The following **Health Screening** benefit shall be included in the **Accident Benefits** section of Your Certificate:

Health Screening Benefit: We will pay the Health Screening Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes a Health Screening Test.

This benefit is payable once per calendar year for each Covered Person. This benefit will not be paid for any day which any other benefit for the same or similar exam, test, or X-Ray is payable.

7. The **Payment of Claims** provision shown in the **Claim Provisions** section of Your Certificate is amended to read as follows:

Payment of Claims: All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:

- (a) Your designated beneficiary(ies); or if none, then to
- (b) Your estate.

Where required by law, benefits paid on behalf of a Covered Person under this Certificate shall be paid to the applicable human services department when:

- (a) the human services department has paid or is paying benefits on behalf of the Covered Person under a state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or

- (b) payment for the services in question has been made by the human services department to a Medicaid provider; and
- (c) We are notified that the Covered Person receives benefits under the Medicaid program.

8. The following **Beneficiary Designation** provision shall be included in the **Claim Provisions** section of Your Certificate:

Beneficiary Designation: In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

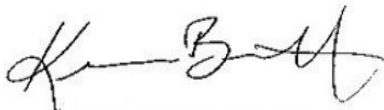
9. The following **Change of Beneficiary** provision shown in the **General Provisions** section shall be included in the **Claim Provisions** section of Your Certificate and is amended to read as follows:

Change of Beneficiary: The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

In all other respects the Certificate remains the same.

Signed for Hartford Life and Accident Insurance Company



Kevin Barnett, *Secretary*



Jonathan Bennett, *President*

Maryland

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

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 or our contracted claim administrator as follows:

**The insurance carrier for the
Policy is:**

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

**The Claims Administrator for
the Policy is:**

**WebTPA
P.O. Box 99906
Grapevine, TX 76099
1-866-547-4205**

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.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

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. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. The **Spouse** definition will always include a registered domestic partnership, any individual who is a partner to a civil union, and any other relationship allowed 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. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

California:

1. **NOTICE:** You and Your Dependent(s) must be insured with major medical insurance in order to be eligible under

the Policy.

2. 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:

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

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

In the event We deny the Covered Person's claim for benefits, in whole or in part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled **Claim Appeal**. If the Covered Person does not appeal the decision to Us, then the decision will be Our final decision.

3. **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
Web Address: www.insurance.ca.gov

Colorado:

1. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition, located in the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
2. The **Spouse** definition also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.
3. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, the Covered Person is entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

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

Connecticut:

1. **NOTICE:** The **Policy** provides limited/supplemental coverage only and does not replace major medical insurance.
2. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
3. Benefits will be payable within 30 days from the date We receive Proof of Loss, as defined in the **Claims Provisions** section of the Certificate; unless if shown as less.
4. **Dependent Child(ren) Coverage Amount**, shown in the **Benefit Schedule**, will be at least 25% of the Primary Insured's Coverage Amount; if elected.

Florida:

1. **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. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The continuously insured time period, as shown in the **Pre-existing Condition Limitation** of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
4. We will pay benefits immediately upon receipt of Proof of Loss.
5. The **Coverage Amount(s)**, as shown in the **Benefit Schedule**, must be elected in increments \$1,000.
6. **Dependent Child(ren)** coverage, as shown in the **Definitions** section, will continue past the attainment age if the child has a disability or handicap which prevents him/her from securing sustainable employment and the child is dependent upon You for financial support. Proof of such handicap or disability must be provided upon request; however after 2 years such proof will only be required once per year.

7. **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
Web Address: <http://insurance.illinois.gov/>
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. 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.

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

Kansas:

1. The following requirement applies to You:

Policy Interpretation:

Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to US the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Therefore, We are a fiduciary for the Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under the Policy. This provision only applies where the interpretation of the Policy is governed by ERISA.

Louisiana:

1. The **Reinstatement after Military Service** provision, if not shown in the **Continuation Provisions** section, applies to you:

Reinstatement after Military Service: If:

- 1) Your coverage terminates because You enter active military service; and
- 2) You are rehired within 12 months of the date You return from active military service;

then coverage for You may be reinstated, provided You request such reinstatement within 30 days of the date You return to work.

The reinstated coverage will:

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

Maine:

1. **NOTICE:** The Policy provides for limited benefits and does not cover all medical expenses. The Certificate, Outline of Coverage, and Buyer's Guide to Cancer Insurance should be reviewed.
2. The continuously insured time period, as shown in the **Pre-existing Condition Limitation** of the **Limitations and Exclusions** section, is 12 consecutive months; unless if shown as less.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
4. Coverage for **Dependent Child(ren)** as shown in the Definitions section, terminates at age 19 for non-students; unless if shown as higher.
5. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
6. **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.

Michigan:

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

Montana:

1. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months, unless if shown as less.
2. Benefits and coverage amounts for a newborn or newly adopted child will be equal to the benefits and coverage

amounts offered under the Policy for Dependent Child(ren), as shown in the **Benefit Schedule**.

3. Coverage for a newly adopted child, as described in the **Eligibility and Enrollment** section, will cease immediately if placement is disrupted or the child no longer is in the custody of You or Your Spouse.
4. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment of any illness or injury within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months, or less if shown in the Certificate. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until the Covered Person has been continuously insured for 6 consecutive months, or less if shown in the Certificate.
3. **Proof of Loss**, as shown in the **Claim Provisions** section, must be provided within 90 days of the date of loss.
4. Part-time employees who work at least 15 hours per week are eligible for coverage.
5. A Dependent will no longer meet the definition of **Dependent Child** upon attainment of age 26.
6. Spouse coverage may be continued under the Policy even after divorce or separation. Coverage may be continued to a maximum of 3 years or earlier if ordered by a divorce decree. The continuation will cease if the Primary Insured dies or the former Spouse remarries.
7. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
8. **Notice: READ YOUR CERTIFICATE CAREFULLY** - You have a 30 day right from the Primary Insured's Coverage Effective Date to examine Your Certificate. If You are not satisfied, You may return it to Us within 30 days from the date You received Your Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
9. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
10. The following **Extension of Coverage while Disabled** provision is added to the **Continuation Provisions** section of the Certificate:

Extension of Coverage while Disabled

If You are Disabled when coverage would otherwise terminate because:

- 1) You are no longer eligible for insurance or are no longer in an Eligible Class; or
- 2) the Policy terminated;

coverage will be extended for 90 days after it would otherwise terminate, while Disability continues.

The following definitions apply to this provision:

Disabled, Disability means that a significant change in Your mental or physical functional capacity has occurred, as a result of which during the initial 12 months of continuous disability You are:

- 1) unable to perform the Material Duties of Your Regular Occupation; and/or
- 2) receiving disability benefits through a disability insurance plan (or equivalent) sponsored by the Policyholder.

Thereafter, You must be continuously unable to perform the Material Duties of any occupation for which You are or may reasonably become qualified based on education, training or experience. At all times while disabled, You must be under the care of a Physician or Medical Professional.

Material Duties means the essential functions, operations and tasks relating to an occupation, as it is normally performed in the general labor market in the United States economy that cannot be reasonably modified or omitted.

Regular Occupation means the occupation You routinely perform at the time Your Disability begins. Your regular occupation is:

- 1) not limited to Your specific position with the Policyholder; and
- 2) is inclusive of any similar position or activity based on job descriptions included in the most recent edition of the United States Department of Labor Dictionary of Occupational Titles (or equivalent source), as normally performed in the United States economy (not specific to any employer, location, area or region).

11. We will refund the pro rata portion of any premium paid for You or Your covered Dependents while You or Your covered Dependents are in the armed forces on full-time active duty, if coverage is excluded during this period.
12. **Notice:** **This is a Limited Policy - Read it Carefully**
13. **Notice:** This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the Outline of Coverage and the "Buyer's Guide."

New Jersey:

1. All coverage amounts, as shown in the **Benefits Schedule**, must be elected in increments of \$1,000. Spouse and Dependent Child(ren) coverage will be a minimum of 25% of the **Primary Insured Coverage Amount**.
2. The **Lodging Benefit, Transportation Benefit, Prosthesis/Wig Benefit, Rehabilitation Benefit, Home Health Care Benefit, and Physical Therapy Benefits**, if shown in the **Benefit Schedule** section, are not available to New Jersey residents.
3. The **Health Screening Benefit**, if shown in the **Benefit Schedule** section, is payable at \$50 per year.

New Mexico:

1. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
2. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.
3. **NOTICE TO CONSUMER: This is a limited benefit health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-3935 (TTY: 711)**
4. Benefits paid on behalf of a Covered Person under this certificate shall be paid to the Human Services Department when:
 - a. the Human Services Department has paid or is paying benefits on behalf of the Covered Person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
 - b. payment for the services in question has been made by the Human Services Department to the Medicaid provider; and
 - c. We are notified that the Covered Person receives benefits under the Medicaid program and that benefits must be paid directly to the Human Services Department.
5. If You are covered under a Non-ERISA policy issued outside of New Mexico with a certificate effective date of January 1, 2019 or later, these additional requirements apply to you:

Consumer Complaint Notice

If you are resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding your claim, premium, or other matters pertaining to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/>

- A. Benefits payable under this Certificate will be paid immediately after Our receipt of due written proof of loss. If a claim is paid more than 45 days from receipt of required **Proof of Loss**, You are entitled to interest on that amount at the rate of 1 1/2 times the prime lending rate, as determined by the superintendent, for New Mexico banks per year during the period the claim is unpaid.
- B. **Legal Actions** may not start until 60 days after proof of loss is given or more than 3 years after the time proof of loss is required to be given.
- C. **Physician** means a person who is:

- a. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art recognized by New Mexico law;
- b. licensed to practice in the jurisdiction where care is being given;
- c. operating within the scope of his or her license; and
- d. not the Covered Person or a Family Member.

You have full freedom of choice in the selection of a Hospital for care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice for the treatment of any Critical Illness within the scope and limitations of his or her practice.

- D. If an unmarried child is age 26 or older and is:
 - a. incapable of self-sustaining employment because of an intellectual disability or physical handicap;
 - b. chiefly dependent on You for financial support;
 and You have provided proof of his/her disability upon Our request, that child will continue to be a **Dependent Child** until these conditions cease to exist. We may request that proof of such incapacity and dependency is furnished to us within 31 days of the child's attainment age 26 and subsequently as may be required by us, but not more frequently than annually after the two year period following the child's attainment age of 26.
 - E. **Newborn and Newly Adopted Child Coverage:**
 If, while covered under the Policy, You:
 - a. have a newborn child;
 - b. adopt a child;
 - c. receive a stepchild; or
 - d. become the legal guardian of a child;
 the child will become covered under the Policy for 31 days after the date the child becomes eligible. Benefits and amounts will be the minimum amount for those We are providing for Dependent Child(ren) under the Policy at that time.
- Coverage of the new child will cease after 31 days from the date the child became eligible unless You:
- a. enroll the new child prior to the expiration of the 31 days; and
 - b. pay the additional required premium.
- F. After a **Covered Person** has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period. In order to be used, the statement must be in writing and signed by You and Your Spouse.

New York:

- 1. **NOTICE:** The Certificate is a group certificate. The Certificate provides specified disease coverage ONLY. The Certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

North Carolina:

- 1. No statements will be used to reduce or deny a claim if the Covered Person has been insured under the Policy for at least 2 years. Prior to 2 years, such statement must be in writing and signed by the Covered Person in order to be used.
- 2. **Notice of Claim**, as shown in the **Claim Provisions** section, should be sent to:
 WebTPA, Inc.,
 P.O. Box 99906
 Grapevine, TX 76099.
- 3. **Proof of Loss**, as shown in the **Claim Provisions** section, must be provided within 180 days from the date of loss.
- 4. Benefits will be paid immediately upon receipt of **Proof of Loss**.

Oregon:

- 1. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.
- 2. The **Spouse** definition will always include domestic partners, civil unions, and any other arrangement allowable by state law.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section, is not applicable.
2. Coverage will be continued for a period of at least 5 but no greater than 30 consecutive days if Your Dependent enters into active military service outside of the continental United States. Please see Your Employer for additional eligibility requirements.

South Dakota:

1. No benefit or increase in benefits will be payable for a Critical Illness that was caused or contributed by a **Pre-existing Condition** as described in the **Exclusions and Limitations** section during the first 12 months from the Policy Effective Date.
2. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
3. The definition of **Physician** will include a Family Member if such person is the only doctor in the area acting within the scope of practice.

Texas:

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

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. Proof of disability or handicap of a **Dependent Child**, as described in the **Definitions** section, will not be requested more frequently than once every two years.

Vermont:

1. The **Waiting Period**, if shown in the **Benefit Schedule**, is not applicable.

Virginia:

1. The definition of **Spouse** only includes anyone who is recognized as a spouse under Virginia state law.
2. Domestic partners and other relationships allowable by Virginia state law are eligible for Dependent coverage; if Dependent coverage is available under the Policy.
3. **For Your Questions and Complaints:**
State Corporation Commission
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

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)

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.



Policyholder: LIMRiCC

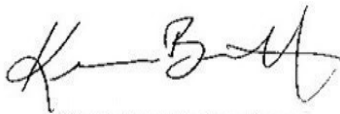
Policy Number: VCI-891881

Policy Effective Date: July 1, 2023

Policy Anniversary Date: January 1

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


Kevin Barnett, Secretary


Jonathan Bennett, President

THIS IS A LIMITED BENEFIT CERTIFICATE: This Certificate provides limited or supplemental coverage. It pays benefits **ONLY** upon the occurrence and Diagnosis of a Critical Illness with the exception of the Health Screening Benefit. This Certificate does not provide benefits for any other disease, sickness or incapacity. Benefits provided are supplemental and are not intended to substitute for medical coverage or disability insurance.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from Us.

READ YOUR CERTIFICATE CAREFULLY: You have a 30 day right from the Primary Insured's Coverage Effective Date to examine Your Certificate. If You are not satisfied, You may return it to Us within 30 days from the date You received Your Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30 day period will be deducted from the refund.

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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BENEFIT SCHEDULE

Eligible Class(es) for Coverage: All Part-time Active Employees scheduled to work at least 20 hours per week and who are citizens or legal residents of the United States of America, its territories and protectorates; excluding temporary, leased or seasonal employees.

Waiting Period: 12 months

The time period(s) referenced above is continuous.

Cost of Coverage:

Contributory – You must contribute toward the cost of coverage.

Coverage Amount:

Primary Insured: Option 1: \$10,000

Option 2: \$20,000

Spouse: 100% of the Primary Insured Coverage Amount

Dependent Child(ren): 50% of the Primary Insured Coverage Amount

Guaranteed Issue Amount: \$20,000

Primary Insured Coverage Maximum:

You may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 500% of the Primary Insured's Critical Illness Coverage Amount is reached in Your lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Spouse Coverage Maximum:

Your Spouse may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 500% of the Spouse's Critical Illness Coverage Amount is reached in Your Spouse's lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Child(ren) Coverage Maximum:

Each Child may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 300% of the Child's Coverage Amount is reached while covered as a Dependent Child under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Disclosure of Services:

In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

CRITICAL ILLNESS BENEFITS

Critical Illnesses	Percentage of Coverage Amount
<u>Cancer Benefits</u>	
Invasive Cancer	100%
Non-Invasive Cancer	25%
Benign Brain Tumor	25%
Non Melanoma Skin Cancer	\$250 once per lifetime per Covered Person
<u>Vascular Benefits</u>	
Heart Transplant	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Bypass Graft	25%
Aneurysm	50%
Angioplasty/Stent	25%
<u>Other Specified Critical Illness Benefits</u>	
Coma	100%
Paralysis	100%
Major Organ Transplant	100%
End Stage Renal Disease	100%
Loss of Hearing	100%
Loss of Speech	100%
Loss of Vision	100%
Bone Marrow Transplant	25%
<u>Neurological Benefits</u>	
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease")	100%
Advanced Multiple Sclerosis	100%
Advanced Alzheimer's Disease	100%

Each covered Critical Illness Benefit listed will only be paid once for each Covered Person.

<u>Recurrence Benefit</u>	<u>Percentage of Original Benefit Amount</u>
Invasive Cancer	100%
Benign Brain Tumor	100%
Heart Transplant	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coma	100%
Major Organ Transplant	100%

Subject to the Covered Person's coverage maximum shown above, the Recurrence Benefit is only payable if a Critical Illness Benefit has been paid for the same Critical Illness. In order to receive a Recurrence Benefit, all other conditions stated in the Recurrence Benefit provision must be satisfied. Only one Recurrence Benefit is payable for each covered benefit.

ADDITIONAL CRITICAL ILLNESS BENEFITS

<u>Benefits</u>	<u>Coverage Amount</u>
Health Screening Benefit	\$50 per day

DEFINITIONS

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

Actively at Work means that You are performing all the regular duties of Your job in the usual way and for the usual number of hours at the Policyholder's normal place of business or a site where the Policyholder's business requires You to travel.

You are considered Actively at Work on any day that is not Your regular scheduled work day (e.g., You are on vacation or holiday) as long as You were Actively at Work on Your immediately preceding scheduled work day.

Advanced Multiple Sclerosis ("MS") means a condition Diagnosed as the occurrence of at least two episodes of well-defined neurological abnormalities, with objective evidence of lesions that are characteristic of MS at more than one site within the central nervous system. Advanced Multiple Sclerosis must be Diagnosed by a Physician who is a board certified neurologist and the Diagnosis must be supported by modern imaging, investigative techniques and/or analysis of cerebrospinal fluid consistent with the Diagnosis.

The initial Diagnosis of Advanced MS must occur while the Covered Person is covered under the Policy.

Advanced Parkinson's Disease means a condition Diagnosed as Parkinson's Disease which has progressed to a classification of Stage 4 or greater. Diagnosis must be made by a board certified or board eligible neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. Other Parkinsonian syndromes are not included in this definition.

The initial Diagnosis of Advanced Parkinson's Disease must occur while the Covered Person is covered under the Policy.

Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease") means a condition Diagnosed as progressive degenerative motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a degeneration of anterior horn cells of the spinal cord and cranial nerves and is Middle Stage according to the Muscular Dystrophy Association. Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician who is a board certified neurologist based on generally acceptable principles of medicine.

The initial Diagnosis of ALS must occur while the Covered Person is covered under the Policy.

Aneurysm means a condition Diagnosed as a localized, blood-filled dilation of a blood vessel caused by disease or weakening of the vessel wall in the brain, carotid arteries, or aorta for which surgical correction has been performed or is Medically Necessary. Aorta refers to the thoracic and abdominal aorta, but not its branches. Diagnosis must be supported by medical records which include radiographically specific studies such as, but not limited to, angiography, CT scan, MRI, or ultrasound.

Angioplasty/Stent means a condition Diagnosed as heart disease that has progressed such that reconstitution or recanalization of a blood vessel is Medically Necessary. Angioplasty surgery may involve balloon dilation, mechanical stripping of intima, forceful injection of fibrinolytics or placement of a stent.

Annual Enrollment Period means a date determined by the Policyholder on a yearly basis.

Benign Brain Tumor means a condition Diagnosed as a non-malignant tumor or cyst in the brain, cranial nerves or meninges within the skull with a minimum size of 1 cm, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms. The tumor, including its size, should be documented on an MRI of the brain (with and without contrast) or by pathological diagnosis. If the Covered Person is unable to undergo an MRI of the brain (the study is deemed inappropriate for safety reasons such as the presence of metallic foreign bodies; mechanical reasons such as body habitus; or unavailability), then the tumor should be documented by a CT scan of the head, with and without contrast.

Benign Brain Tumor does not include:

- 1) tumors in the pituitary gland; or
- 2) angiomas.

Bone Marrow Transplant means a condition Diagnosed as leukemia, lymphoma, aplastic anemia, or other disease of the bone marrow and which requires the replacement of the Covered Person's bone marrow by autologous, allogeneic, and/or umbilical cord blood transplant. A Physician must have determined the replacement is Medically Necessary.

If the Covered Person is too ill to undergo the replacement, but otherwise meets the criteria for the need for the replacement, the replacement requirement is waived.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable and exclusions and limitations that apply to coverage.

Change in Family Status means one of the following events:

- 1) You get married or enter into a legal relationship recognized as a Spouse;
- 2) You and Your Spouse divorce or legally terminate Your relationship;
- 3) Your child is born or You adopt, You receive a step child or become the legal guardian of a child;
- 4) Your Spouse dies;
- 5) Your child is no longer a Dependent Child or dies;
- 6) Your Spouse is no longer employed, which results in a loss of critical illness insurance sponsored by the Spouse's employer; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

Coma means a condition Diagnosed as a continuous state of profound unconsciousness with no reaction to external stimuli which is not the result of a Stroke. The Coma must:

- 1) be due to disease;
- 2) be Diagnosed after the Policy Effective Date;
- 3) last for a period of 7 or more consecutive days; and
- 4) be rated/classified by at least one of the following scales:
 - a) Rancho Los Amigos Scale (RLAS) as a level I or II;
 - b) Glasgow Coma Scale values of 3 through 5; or
 - c) the disability rate scale with values of 22 through 29.

The condition must require mechanical ventilation for respiratory assistance. For purposes of the Policy, Coma does not include a medically induced coma or a coma caused by alcohol or substance use disorder.

Contributory Coverage means coverage for which You are required to contribute toward the cost.

Coronary Artery Bypass Graft means a condition Diagnosed as heart disease that necessitates heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be Medically Necessary as determined by a Physician board certified in cardiology.

Coverage Amount is the dollar amount You or Your Dependents are covered for a Critical Illness.

Covered Person means the Primary Insured and all Dependents.

Critical Illness means any of the conditions shown in the Benefit Schedule.

Dependent or Dependents means Your Spouse and Your Dependent Child(ren) covered by the Policy.

Dependent Child(ren) means Your or Your Spouse's natural children, step-children, legally adopted children, children placed into Your custody for adoption or children for whom You are ordered by a court or administrative order to provide coverage regardless of whether You are the custodial or non-custodial parent who are under 26 years of age.

If an unmarried child is age 26 or older and is:

- 1) incapable of self-sustaining employment because of a mental or physical disability;
- 2) chiefly dependent on You for financial support;

and You have provided proof of his/her disability upon Our request, that child will continue to be a Dependent Child until these conditions cease to exist.

Coverage for a dependent child may be continued to age 30 if the unmarried child

- 1) is an Illinois resident,
- 2) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States; and

- 3) has received a release or discharge other than a dishonorable discharge and who qualifies as a legal dependent for tax exemption purposes under the United States Internal Revenue Service Tax Code.

Diagnosed, Diagnosis means the definitive establishment of a Critical Illness through the use of clinical or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required in the Policy.

End Stage Renal Disease means a condition Diagnosed as kidney disease which has resulted in permanent and irreversible failure of both kidneys requiring regular treatment by either hemodialysis or peritoneal dialysis on a no less than weekly basis, or for which kidney transplant is Medically Necessary.

Family Member means the Covered Person's parent, spouse, domestic partner, children, siblings, grandparent, aunt, uncle, first cousin, nephew or niece. This includes adopted, in-law and step-relatives.

Heart Attack means a condition Diagnosed as acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician board certified in cardiology. Significant electrocardiogram (EKG) changes must be seen and the Diagnosis of an acute myocardial infarction (heart attack) with resulting loss of normal heart function must be confirmed by one or both of the following:

- 1) a clinical picture of myocardial infarction with cardiac enzyme changes found in blood (elevated CK-MB isoenzyme fraction or elevated troponins);
- 2) confirmatory imaging tests such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

Heart Attack does not include:

- 1) established (old) myocardial infarction;
- 2) congestive heart failure;
- 3) atherosclerosis;
- 4) angina;
- 5) coronary artery disease;
- 6) or any other dysfunction of the cardiovascular system;
- 7) cardiac arrest not caused by a myocardial infarction; or
- 8) heart attacks that occur during clinical procedures.

In the event of death, an autopsy confirmation and/or death certificate identifying Heart Attack as the cause of death will be accepted.

Heart Transplant means:

- 1) a condition Diagnosed as heart failure due to heart disease and placed on a national transplant list such as UNOS; and
- 2) the irreversible failure of the Covered Person's heart has occurred for which a Physician has determined that the replacement of such organ with a human donor heart is Medically Necessary.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement on such list will be waived.

Home Office means Our office at One Hartford Plaza, Hartford, Connecticut 06155.

Hospital means an institution:

- 1) licensed to operate as a Hospital pursuant to law;
- 2) primarily and continuously engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
- 3) providing twenty-four hour nursing service by or under the supervision of registered nurses (RNs).

Hospital does not include:

- 1) convalescent homes, or convalescent, rest or nursing facilities;
- 2) facilities affording primarily custodial, educational or rehabilitative care; or

- 3) facilities primarily for the aged, drug addicts or alcoholics.

Invasive Cancer means a condition Diagnosed as the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells with invasion of normal tissue as diagnosed by a Physician, who is board certified in the medical specialty that is appropriate for the type of cancer involved.

Invasive Cancer includes any cancer classified as Stage 2 through 4, or its equivalent.

Invasive Cancer does not include a Diagnosis of Invasive Cancer for:

- 1) any tumor in the presence of human immuno-deficiency virus;
- 2) any non-melanoma skin cancer; or
- 3) any condition that is considered Non-Invasive Cancer.

Loss of Hearing means a condition Diagnosed as the irreversible loss of hearing for all sounds in both ears, due to disease. The Diagnosis of irreversible loss of hearing must be made by a licensed professional or specialist in the applicable field of medicine and established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels in both ears while utilizing a hearing aid.

The loss of hearing must occur after the Covered Person becomes insured under the Policy.

Loss of Speech means a condition Diagnosed as the irreversible loss of ability to speak, due to disease. The Diagnosis of irreversible loss of speech must be made by a licensed professional or specialist in the applicable field of medicine and must include documented evidence of the loss for at least 12 months.

The loss of speech must occur after the Covered Person becomes insured under the Policy.

Loss of Vision means a condition Diagnosed as the irreversible loss of vision in both eyes due to disease. The Diagnosis of irreversible loss of vision must be made by a licensed professional or specialist in the applicable field of medicine and must indicate that corrective visual acuity is equal to or worse than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes.

The irreversible loss of vision must occur after the Covered Person becomes insured under the Policy.

Major Organ Transplant means:

- 1) a Diagnosis of organ failure due to disease of the affected organ and have been placed on a national transplant list such as UNOS; and
- 2) the irreversible failure of the Covered Person's lung, pancreas or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is Medically Necessary; or
- 3) the irreversible failure of the Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is Medically Necessary. For this type of transplant, the requirement of placement on a national transplant list, such as UNOS, is specifically null in cases of live donor transplant.

Organs transplanted simultaneously with the heart are covered under Heart Transplant.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement requirement will be waived.

Medically Necessary means:

- 1) recommended by a Physician acting within the scope of his or her license; and
- 2) consistent with currently accepted medical practice.

Non-Invasive Cancer means a condition Diagnosed as:

- 1) Stage 1 or its equivalent; or
- 2) carcinoma in situ classified as TisNOM0, for which radiotherapy, intravenous chemotherapy, or surgical procedures are Medically Necessary to control or cure the disease.

Non-Invasive Cancer does not include a condition Diagnosed as:

- 1) any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- 2) any tumor in the presence of human immuno-deficiency virus;

- 3) any non-melanoma skin cancer;
- 4) any melanoma in situ classified as TisN0M0 under TNM staging.

Paralysis means a condition Diagnosed as the complete and permanent loss of function of two or more limbs due to disease. Paralysis as a result of Stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness that caused the Paralysis. As used herein, "limb" means an arm or leg.

The Paralysis must occur after the Covered Person becomes insured under the Policy.

Physician means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of 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) operating within the scope of his or her license; and
- 4) not the Covered Person or a Family Member.

Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page, this Certificate and all other riders, amendments and endorsements that make up the contract of insurance.

Primary Insured refers to the Active Employee.

Qualifying Event for You means any termination of coverage under the Policy, prior to age 80, in accordance with the Termination provision for any reason, except:

- 1) non-payment of premium; or
- 2) termination of the group Policy.

Qualifying Event for Your Spouse is Your death or divorce while You are insured under the Policy. The Qualifying Event must occur prior to Your Spouse's attainment of age 80.

Dependent Child(ren) coverage is continued if You or Your Spouse elect to continue coverage due to Your or Your Spouse's own Qualifying Event.

Spouse means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.

Spouse will include those who have entered into a civil union under The Religious Freedom Protection Act and Civil Union Act. 750 ILCS 75/, which allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples.

Stroke means a condition Diagnosed as a cerebrovascular accident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis.

The diagnosis must be supported by:

- 1) evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
- 2) confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

Stroke does not mean a head injury, transient ischemic attack (TIA), or chronic cerebrovascular insufficiency.

Stroke does not include a Diagnosis of Stroke for:

- 1) cerebral symptoms due to migraine;
- 2) cerebral injury resulting from trauma or hypoxia; or
- 3) vascular disease affecting the eye or optic nerve or vestibular functions.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

Waiting Period means the length of time You must be a member in an Eligible Class before You can apply for insurance. The Waiting Period is shown in the Benefit Schedule.

We, Us, Our means Hartford Life and Accident Insurance Company.

You or **Your** refers to the Primary Insured.

ELIGIBILITY AND EFFECTIVE DATES

Primary Insured's Eligibility for Coverage:

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 for Coverage; or
- 3) the date You completed the Waiting Period.

Dependent Eligibility for Coverage:

Your Dependent(s) will become eligible for coverage on the later of:

- 1) the date You become insured for employee coverage; or
- 2) the date You acquire Your first Dependent.

You may not cover Your Dependent if such Dependent is covered as an Active Employee under the Policy. No person can be insured as a Dependent of more than one employee under the Policy.

Enrollment:

To enroll You must:

- 1) complete and sign a group insurance enrollment form, which is satisfactory to Us, for Your and Your Dependent's coverage within 31 days of the date You are eligible for coverage; and
- 2) deliver it to Your Employer.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under the Policy and later choose to enroll, You may only enroll for Your coverage and/or Your Dependent's coverage:

- 1) during an Annual Enrollment Period or any additional enrollment event designated by the Policyholder; or
- 2) within 31 days of the date You have a Change in Family Status.

Primary Insured's Coverage Effective Date:

Coverage will start on the latest to occur of:

- 1) the first of the month on or next following the date You become eligible, if You enroll on or before that date;
- 2) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
- 3) the first day of the month following the last day of the additional enrollment event, if You enroll during an additional enrollment event; or
- 4) the first of the month following the date You enroll, if You do so within 31 days from the date You are eligible.

Dependent Effective Date:

Coverage will start on the latest to occur of:

- 1) the first of the month on or next following the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- 2) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
- 3) the first day of the month following the last day of the additional enrollment event, if You enroll during an additional enrollment event; or
- 4) the first of the month on or next following the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

Changes in Coverage:

You may change Your benefit option only:

- 1) during an Annual Enrollment Period or the first day of the month following the last day of the additional enrollment event; or
- 2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option.

If You enroll for a change in benefit option during an Annual Enrollment Period or any additional enrollment event, the change will take effect on the Policy Anniversary Date following the Annual Enrollment Period or the first day of the month following the last day of the additional enrollment event.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the date You enroll for the change.

Any such increase in coverage is subject to the Pre-existing Conditions Limitations.

Newborn and Newly Adopted Child Coverage:

If, while covered under the Policy, You:

- 1) have a newborn child;
- 2) adopt a child;
- 3) receive a stepchild; or
- 4) become the legal guardian of a child;

the child will become covered under the Policy for 31 days after the date the child becomes eligible. Benefits and amounts will be the minimum amount for those We are providing for Dependent Children under the Policy at that time.

Coverage of the new child will cease after 31 days from the date the child became eligible unless You:

- 1) enroll the new child prior to the expiration of the 31 days; and
- 2) pay the additional required premium.

TERMINATION OF INSURANCE

Termination of Primary Insured's Coverage:

Your coverage will end on the earliest of the following:

- 1) the date the Policy terminates;
- 2) the last day of the month following the date You are no longer in a class eligible for coverage, or the Policy no longer covers Your class;
- 3) the date the required premium is due but not paid;
- 4) the last day of the month following the date You request We terminate Your coverage;
- 5) the last day of the month following the date the Policyholder terminates Your employment; or
- 6) the last day of the month following the date You are no longer Actively at Work;

unless continued in accordance with one of the Continuation Provisions.

Termination of Dependent Coverage:

Coverage for Your Dependent(s) will end on the earliest to occur of:

- 1) the date Your coverage ends;
- 2) the date the required premium is due but not paid;
- 3) the last day of the month following the date You are no longer eligible for Dependent coverage;
- 4) the last day of the month following the date We or the Policyholder terminate Dependent coverage;
- 5) the last day of the month following the date You request We terminate Dependent coverage;
- 6) the last day of the month following the date the child no longer meets the definition of Dependent Child; or
- 7) the last day of the month following the date that You and Your Spouse are no longer married or legally terminate Your relationship;

unless continued in accordance with one of the Continuation Provisions.

CONTINUATION PROVISIONS

Continuation:

Coverage may be continued, at the Policyholder's option beyond a date shown in the Termination of Primary Insured's Coverage provision, if the Policyholder provides a plan of continuation which applies to all employees the same way.

Coverage for Your Dependents will continue if Your coverage is continued.

The amount of continued coverage applicable to You or Your Dependent 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.

The amount of insurance will not increase while coverage is being continued. The Continuation Provisions shown below will not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents 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 (including Dependent coverage) may be continued for 3 month(s) following the date on 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 or Your Dependent enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent coverage) may be continued for up to 3 month(s). 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 Policyholder due to lack of work, all of Your coverage (including Dependent coverage) may be continued for 3 month(s) following the date on which the lay off commenced. If the lay off becomes permanent, this continuation will cease immediately.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, Your coverage (including Dependent coverage) may be continued:

- 1) for a period of 365 consecutive day(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 365 consecutive day(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) (including Dependent coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

CRITICAL ILLNESS BENEFITS

Critical Illness Benefit:

If a Covered Person is Diagnosed with a Critical Illness, while covered under the Policy, We will pay a Critical Illness Benefit. The Critical Illness Benefit is equal to the Coverage Amount multiplied by the Percentage of Coverage Amount for the Critical Illness, as shown in the Benefit Schedule for each Covered Person.

Subject to the Coverage Maximums shown in the Benefit Schedule:

- 1) Cancer Benefits shown in the Benefit Schedule will only be paid once for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Cancer Benefit or a Cancer Recurrence Benefit, a period of 3 months must be satisfied before payment of any other Cancer Benefit;
- 2) Vascular Benefits shown in the Benefit Schedule will only be paid once for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Vascular Benefit or a Vascular Recurrence Benefit, a period of 3 months must be satisfied before payment of any other Vascular Benefit; and
- 3) with the exception of Vascular and Cancer Benefits, there is no period of time to be satisfied before payment of any other Critical Illness Benefit.

Recurrence Benefit:

We will pay a Recurrence Benefit as shown in the Benefit Schedule if a Covered Person receives a Diagnosis of a recurrence of a Critical Illness previously paid under the Policy.

Subject to the Coverage Maximums shown in the Benefit Schedule:

- 1) the condition must be listed as a Recurrence Benefit in the Benefit Schedule; and
- 2) the Diagnosis of recurrence must be made 6 months or more following the initial Critical Illness Diagnosis.

We will not pay more than one Recurrence Benefit per Critical Illness for the Covered Person during the Covered Person's lifetime.

Health Screening Benefit:

For each day a Covered Person has one or more of the screening tests for Critical Illness listed below, not to exceed one day per calendar year, We will pay the Health Screening Benefit stated in the Schedule. The amount stated is the total amount payable in any calendar year regardless of the number of tests or days of tests during that calendar year.

- 1) bone marrow testing;
- 2) CA15-e (cancer antigen 15-3 blood test for breast cancer);
- 3) CA125 (cancer antigen 125 blood test for ovarian cancer);
- 4) CEA (carcinoembryonic antigen blood test for colon cancer);
- 5) chest x-ray;
- 6) colonoscopy;
- 7) flexible sigmoidoscopy;
- 8) hemocult stool analysis;
- 9) mammography; including breast ultrasound;
- 10) Pap smear; including ThinPrep Pap Test;
- 11) PSA (prostate specific antigen blood test for prostate cancer);
- 12) Serum Protein Electrophoresis (test for myeloma);
- 13) Biopsy for Skin Cancer;
- 14) Blood test for triglycerides;
- 15) HPV (Human Papillomavirus) Vaccination;
- 16) lipid panel (total cholesterol count);
- 17) doppler screening for carotids;
- 18) doppler screening for peripheral vascular disease;
- 19) thermography;
- 20) echocardiogram;
- 21) ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
- 22) EKG;
- 23) stress test on bike or treadmill;
- 24) fasting blood glucose test;
- 25) serum cholesterol to determine level of HDL and LDL; or
- 26) COVID-19 testing when performed by an appropriately licensed medical professional.

We will pay:

- 1) regardless of the result of any test; and
- 2) provided the test was conducted while the Covered Person was covered under the Policy.

LIMITATIONS AND EXCLUSIONS

Pre-existing Condition Limitation:

We will not pay any benefit, or any increase in benefits, under the Policy for any Critical Illness that results from, or is caused by, a Pre-existing Condition, unless, at the time the Covered Person is Diagnosed with the Critical Illness, the Covered Person has been continuously insured under the Policy for .

Pre-existing Condition means:

- 1) any Critical Illness; or
 - 2) any manifestations, symptoms, findings, or aggravations related to or resulting from such Critical Illness;
- for which the Covered Person received Medical Care during the period that ends the day before:
- 1) Your effective date of coverage; or
 - 2) the effective date of a Change in Coverage.

In no event will We consider an annual or routine medical examination, test, attendance, observation or screening to be treatment unless it indicates the presence of a Critical Illness or leads to follow up examinations, tests, attendance, observation or screening which results in the Diagnosis of a Critical Illness.

All manifestations, symptoms, or findings which result:

- 1) from the same or related Critical Illness; or
- 2) from any aggravations of a Critical Illness;

are considered to be the same Critical Illness for the purpose of determining a Pre-Existing Condition.

Medical Care is received when a Physician:

- 1) is consulted or gives medical advice; or
- 2) recommends, prescribes, or provides treatment.

Exclusions:

No benefits are payable under this Certificate for Critical Illness that results from or is caused by:

- 1) war or act of war, declared or undeclared;
- 2) the Covered Person's participation in a felony, riot or insurrection;
- 3) the Covered Person's engaging in any illegal occupation; or
- 4) the Covered Person's service in the armed forces or units auxiliary to them.

CLAIM PROVISIONS

Notice of Claim:

Written Notice of Claim must be given to Us within 20 days after the start of any loss covered by this Certificate, or as soon as is reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us. Notice shall be given to us at The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099.

Claim Forms:

When We receive written Notice of Claim, We will send claim forms. If the claimant does not receive the forms within 15 days after written notice of claim is sent, proof of loss may be sent to Us without waiting to receive the claim forms.

Proof of Loss:

The claimant must send written proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Time of Payment of Claims:

Benefits payable under this Certificate will be paid within 30 days after Our receipt of due written proof of loss.

Payment of Claims:

All payments are payable to You. Any payments owed at Your death may be paid to Your estate in a lump sum.

Claim Denial:

If a claim for benefits is denied, You 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 Policy provisions on 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:

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 a Critical Illness; or
 - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of a Critical Illness or other loss; 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.

Overpayment Recovery:

We have the right to recover from the Primary Insured any amount that is determined to be an overpayment. The Primary Insured has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, the Primary Insured must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

- 1) recover such overpayments from:
 - a) the Primary Insured;
 - b) any other person to or for whom payment was made; and
 - c) the Primary Insured's estate;
- 2) reduce or offset against any future benefits payable to the Primary Insured or his/her survivors until full reimbursement is made;
- 3) refer the Primary Insured's unpaid balance to a collection agency; and
- 4) pursue and enforce all legal and equitable rights in court.

PORTABILITY

Portability Benefit:

Portability allows You or Your Dependents to continue coverage under a group portability policy when coverage ends under this Certificate due to a Qualifying Event. If You or Your Dependents qualify for, and elect Portability as stated in this provision, coverage will continue under a group portability policy subject to the Exclusions provision.

The terms, conditions and premium rates of the portability coverage will be governed by the portability policy and may not be the same as those under this group Critical Illness Policy. You and Your Spouse's coverage under the portability policy will not continue past the Primary Insured's attainment of age 80.

Electing Portability:

You may elect Portability if Your Critical Illness insurance ends due to a Qualifying Event. You may also elect Portability for Your Dependent's coverage if Your coverage ends due to Your own Qualifying Event. The Policy must still be in force for Portability to be available.

Your Spouse may elect Portability for him or herself and Your Dependent Children if Your coverage under the Policy ends due to Your death or divorce, if Your Spouse is under age 80 at the time of the Qualifying Event.

To elect Portability, You or Your Spouse if coverage ends due to Your death must:

- 1) complete a Portability application;
- 2) submit the application to Us, with the required premium; and

this must be received within 31 days after Critical Illness 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; and
- 3) effective on the day following the date Your or Your Spouse's coverage ends, such that there is no interruption in coverage between the Policy and the portability policy.

Limitations on Portability:

You may apply for portable insurance for each Covered Person's Critical Illness benefits in force under the Policy on the date Your insurance terminates.

Your Spouse may apply for portable insurance for the amount of Spouse Coverage and Dependent Children Coverage in force under the Policy on the date of Your death or divorce.

Your Spouse may apply for portable insurance for a Dependent Child whose insurance has terminated.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to Your or Your Spouse's own Qualifying Event.

Portability is not available for any amount of Critical Illness insurance for which You or Your Dependents were not eligible and covered. The amount of Critical Illness insurance for each Covered Person under the portability policy will be the same as the benefits shown in the Benefits Schedule that is in force on the day coverage ends under this Certificate, less any benefits in effect that are paid under this Certificate.

In addition, Portability is not available if You or Your Dependents are entering active military service.

GENERAL PROVISIONS

Statements:

In the absence of fraud, all statements made by the Policyholder or any Covered Person will be considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or personal representative.

Time Limit on Certain Defenses:

After a Covered Person has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period. In order to be used, the statement must be in writing and signed by You and Your Spouse.

Legal Actions:

No legal action may start:

- 1) until 60 days after proof of loss has been given;
- 2) more than 3 years after the time proof of loss is required to be given.

Misstatement of Age:

If the age of any Covered Person has been misstated:

- 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.

Insurance Fraud:

Insurance fraud occurs when You, Your Dependents and/or the Policyholder 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, Your Dependents and/or the Policyholder 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, Your Dependents and/or the Policyholder perpetrate insurance fraud.

Conformity with State Statutes:

Any provision of the Policy which, on its effective date, conflicts with any applicable law is amended to meet the minimum requirements of the law.

Time Periods:

All periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

Workers' Compensation:

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



HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

This rider forms a part of a Certificate given in connection with the Policy.

This rider becomes effective on July 1, 2023.

With respect to All Part-time Active Employees, Your Certificate is amended as follows:

1. The following **Advanced Alzheimer's Disease** definition shall be included in the **Definitions** section of Your Certificate:

Advanced Alzheimer's Disease means a condition Diagnosed as Alzheimer's disease that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST). Diagnosis must be made by a Physician who is a board-certified neurologist, and must be supported by neurological examination and cognitive testing for the involved condition/illness. There must be permanent clinical loss of the ability to do all of the following:

- 1) remember, reason, and perceive; and
- 2) understand, express and give effect to ideas.

Other types of dementia are not included in this definition. The initial Diagnosis of Alzheimer's disease must occur while the Covered Person is insured under the Policy.

2. The following **Confined, Confinement** definition shall be included in the **Definitions** section of Your Certificate:

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 20 consecutive hours.

3. The following **Confined Elsewhere** definition shall be included in the **Definitions** section of Your Certificate:

Confined Elsewhere means a Dependent is unable to perform, unaided, the normal functions of daily living, or leave his/her home or other place of residence without assistance.

4. The definition of **Critical Illness** shown in the **Definitions** section of Your Certificate is amended to read as follows:

Critical Illness means any of the conditions shown in the Benefit Schedule for which a Covered Person is Diagnosed after the effective date of coverage under the Policy for the Covered Person. This definition does not include the recurrence of an Invasive Cancer or Non-Invasive Cancer that was Diagnosed before the effective date of insurance for a Covered Person unless, after the previous Diagnosis and before the date of the subsequent Diagnosis, We receive medical evidence that the Covered Person is considered to be in complete remission with no evidence of disease (NED) for the previous Diagnosis.

5. The definition of **Diagnosis** shown in the **Definitions** section of Your Certificate is amended to read as follows:

Diagnosed, Diagnosis means the definitive establishment of a Critical Illness through the use of clinical or pathological findings. We will accept a clinical Diagnosis only if a pathological Diagnosis cannot be made. The Diagnosis must be made by a Physician who is a board certified specialist where required in the Policy.

The date of Diagnosis under the Policy for a pathological Diagnosis is the date the tissue specimen, blood samples, titers, cultures or preparations are taken on which the eventual Diagnosis is based.

6. The following **Non-Melanoma Skin Cancer** definition shall be included in the **Definitions** section of Your Certificate:

Non-Melanoma Skin Cancer means basal cell carcinoma and squamous cell carcinoma. Actinic keratosis is not included in this definition.

7. The following **Deferred Coverage Effective Date** provision shall be included in the **Eligibility and Effective Dates** section of Your Certificate:

Deferred Coverage Effective Date:

All coverage effective dates, Changes in Coverage effective dates and Reinstatement of Coverage effective dates for an Employee and any Dependent(s) will be deferred if an Employee is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the day after the date the Employee has completed one full day of active work.

All coverage effective dates, Changes in Coverage effective dates, New Dependent Coverage effective dates and Reinstatement of Coverage effective dates for a Dependent will also be deferred if on the date the Dependent is to become covered, he or she is Confined or Confined Elsewhere. Such coverage will not start until the day after the Dependent:

- 1) is no longer Confined or Confined Elsewhere; and
- 2) has engaged in all of the normal and customary activities of a person of like age, gender and good health for at least 15 consecutive days.

In no event will Dependent insurance become effective before an Employee becomes insured.

This provision does not apply to:

- 1) any newborn Dependent Child, regardless of Confinement; or
- 2) any disabled child who qualifies under the definition of Dependent Child(ren).

8. The **Changes in Coverage** provision shown in the **Eligibility and Effective Dates** section of Your Certificate is amended to read as follows:

Changes in Coverage:

An Employee may:

- 1) elect, increase, decrease, drop or otherwise change coverage during an Annual Enrollment Period or any additional enrollment event; or
- 2) increase, decrease, drop or otherwise change coverage within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on:

- 1) the Policy anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
- 2) the first day of the month following the last day of an additional enrollment event, if the change is requested during such event; or
- 3) the date on which the change is requested following a Change in Family Status;

subject to the Deferred Coverage Effective Date provision.

An initial period of coverage for a new Dependent may be available under the New Dependent Coverage provision.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the date of the request or change.

9. The **Newborn and Newly Adopted Child Coverage** provision shown in the **Eligibility and Effective Dates** section of Your Certificate is removed in its entirety and replaced with the following:

New Dependent Coverage:

If You:

- 1) marry or enter a partnership with an individual who satisfies the definition of Spouse; or
 - 2) acquire a child who satisfies the definition of Dependent Child(ren);
- while covered under the Policy, the new Dependent will be automatically covered under the Policy for 31 days from the date of marriage, partnership or acquisition, subject to the Deferred Coverage Effective Date provision.

If Dependent coverage requires an election under the Policy, You must enroll the Dependent for coverage subject to the Changes in Coverage provision in order for the Dependent to remain insured beyond the initial 31 day period.

10. The following **Reinstatement of Coverage** section shall be included in Your Certificate, immediately following the **Termination of Insurance** section:

REINSTATEMENT OF COVERAGE

Reinstatement of Coverage:

Coverage for an Employee and any previously insured Dependent(s) under the Policy may be reinstated after it ends if:

- 1) the Employee returns to an Eligible Class for Coverage within 12 months from the date coverage ended; and
- 2) reinstatement is requested within 31 days from his/her return to an Eligible Class for Coverage, if coverage requires an election under the Policy;

except for coverage that ended due to non-payment of premium or voluntary termination of coverage by an Employee.

We will credit any time the Employee and any Dependent(s) were previously insured under the Policy toward the satisfaction of the Waiting Period.

Reinstated coverage will become effective on the first of the month following the date on which the reinstatement is requested, subject to the Deferred Coverage Effective Date.

Reinstated coverage is subject to all other terms and provisions of the Policy.

If coverage ended due to non-payment of premium or voluntary termination of coverage by an Employee, reinstatement is not available. The Employee may not re-enroll until the next Annual Enrollment Period or additional enrollment event occurs.

Reinstatement is also not available for coverage that an Employee or any Dependent(s) continued under the Portability provision; unless such coverage is cancelled or surrendered.

11. The **Critical Illness Benefit** provision shown in the **Critical Illness Benefits** section of Your Certificate is amended to read as follows:

Critical Illness Benefit:

If a Covered Person is Diagnosed with a Critical Illness while covered under the Policy, We will pay a Critical Illness Benefit. The Critical Illness Benefit is equal to the Coverage Amount multiplied by the Percentage of Coverage Amount for the Critical Illness, as shown in the Benefit Schedule for each Covered Person.

Subject to the Coverage Maximums shown in the Benefit Schedule, each benefit shown in the Benefit Schedule will be paid once for each Covered Person, unless a Recurrence Benefit is available. After the Diagnosis of a Critical Illness for which benefits are paid under the Policy, We will pay benefits for the Diagnosis of each subsequent, different Critical Illness under the Policy subject to the following:

- 1) the date of Diagnosis for the new Critical Illness is separated from the date of Diagnosis for the prior, different Critical Illness by at least 3 months; and
- 2) the new Critical Illness is not caused or affected by a Critical Illness for which benefits have previously been paid under the Policy.

The 3 month separation period noted above applies to the Diagnosis of any Critical Illness with a Percentage of Coverage Amount of 100%. Following the Diagnosis of any Critical Illness with a Percentage of Coverage Amount of 25% or 50%, there is no period of time to be satisfied before Diagnosis of any other Critical Illness.

12. The **Pre-existing Condition Limitation** provision shown in the **Limitations and Exclusions** section of Your Certificate will no longer apply, and is removed in its entirety.

13. The **Payment of Claims** provision shown in the **Claim Provisions** section of Your Certificate is amended to read as follows:

Payment of Claims:

All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:

- 1) Your designated beneficiary(ies); or if none, then to
- 2) Your estate.

Where required by law, benefits paid on behalf of a Covered Person under this Certificate shall be paid to the applicable human services department when:

- 1) the human services department has paid or is paying benefits on behalf of the Covered Person under a state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
- 2) payment for the services in question has been made by the human services department to a Medicaid provider; and
- 3) We are notified that the Covered Person receives benefits under the Medicaid program.

14. The following **Beneficiary Designation** and **Change of Beneficiary** provisions shall be included in the **Claim Provisions** section of Your Certificate following the **Payment of Claims** provision:

Beneficiary Designation:

In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

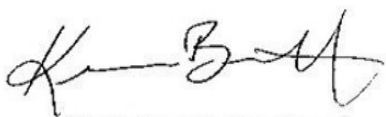
Change of Beneficiary:

The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

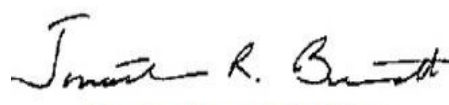
The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

In all other respects the Certificate remains the same.

Signed for Hartford Life and Accident Insurance Company



Kevin Barnett, *Secretary*



Jonathan R. Bennett, *President*

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

OTHER DREAD DISEASE RIDER

This rider is part of the Certificate to which it is attached. It takes effect on July 1, 2023. It is part of and subject to the other terms and conditions of the Certificate, except as noted below. If the terms of this rider and the Certificate conflict, then this rider's provisions will control with respect to the benefits and provisions included in this rider. Capitalized terms used in this rider have the meanings assigned to them in this rider or in the Definitions section of the Certificate.

This rider provides the Covered Person with a benefit if he/she is Diagnosed with an Other Dread Disease after the effective date of this rider while covered under the Policy.

RIDER SCHEDULE

Critical Illness	Benefit Amount
Other Dread Disease	25% of the Coverage Amount for the Covered Person

DEFINITIONS

Diagnosed, Diagnosis means the definitive establishment of an Other Dread Disease as defined in this section of this rider.

Other Dread Disease means a covered severe disease that results in a Covered Person being confined to a Hospital for five (5) or more consecutive days. Covered severe diseases are:

- 1) Addison's disease (primary adrenal insufficiency/hypocortisolism);
- 2) bacterial cerebrospinal meningitis;
- 3) COVID-19, formally SARS-CoV-2/2019-nCoV;
- 4) diphtheria;
- 5) encephalitis;
- 6) Huntington's chorea;
- 7) Legionnaire's disease;
- 8) malaria;
- 9) myasthenia gravis;
- 10) necrotizing fasciitis;
- 11) osteomyelitis;
- 12) poliomyelitis;
- 13) rabies;
- 14) sickle cell anemia (excluding sickle cell trait);
- 15) systemic lupus erythematosus (SLE);
- 16) systemic sclerosis (scleroderma);
- 17) tetanus; and
- 18) tuberculosis.

In the event of death of a Covered Person, a death certificate identifying a covered severe disease as the cause of death will satisfy this definition in lieu of the Hospital confinement requirement.

BENEFITS

We will pay the applicable Critical Illness Benefit Amount shown in the Rider Schedule if a Covered Person is Diagnosed with an Other Dread Disease after the effective date of insurance under this rider for the Covered Person. Once a benefit has been paid for an Other Dread Disease for a Covered Person no further benefit is payable under this rider for the Covered Person.

Once a benefit has been paid for an Other Dread Disease for a Covered Person, insurance for that Covered Person under this rider will terminate. Insurance for any other Covered Person(s) will remain in effect, subject to this limitation.

Payment of any benefit under this rider is subject to the Coverage Maximum for the Covered Person as stated in the Benefit Schedule section of the Certificate. In no event will total benefits paid for any Critical Illness under the Certificate or this rider exceed the applicable Coverage Maximum.

PORTABILITY

Portability

This provision is not applicable to insurance under this rider.

LIMITATIONS AND EXCLUSIONS

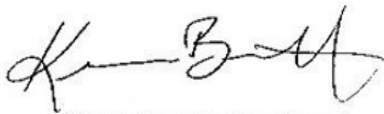
Limitations

All limitations as stated in the Limitations and Exclusions section of the Certificate are applicable to the benefits under this rider.

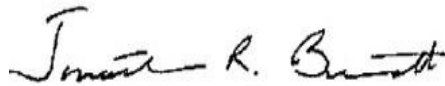
Exclusions

All exclusions as stated in the Limitations and Exclusions section of the Certificate are applicable to the benefits under this rider.

Signed for Hartford Life and Accident Insurance Company at Hartford, Connecticut.



Kevin Barnett, *Secretary*



Jonathan Bennett, *President*

**NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
 - \$300,000 for death benefits
 - \$100,000 for cash surrender of withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans*
 - \$300,000 for disability insurance benefits
 - \$300,000 for long-term care insurance benefits
 - \$100,000 for other types of health insurance benefits
- Annuities
 - \$250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

<i>Illinois Life And Health Insurance Guaranty Association 901 Warrenville Road, Suite 400 Lisle, IL 60532-4324</i>	<i>Illinois Department Of Insurance 4th Floor 320 West Washington Street Springfield, IL 62767</i>
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Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on the Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

This Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.



Hartford Life and Accident Insurance Company ("The Hartford" or "we") is committed to protecting the privacy of your health information. The Hartford is required by a federal law - the Health Insurance Portability and Accountability Act (HIPAA) - to take reasonable steps to ensure the privacy of your "Protected Health Information" (PHI) and to provide you with this Notice of Privacy Practices. PHI includes all individually identifiable health information transmitted or maintained by The Hartford and/or its business associates regardless of form (oral, written, electronic).

This Notice applies to PHI obtained through the following coverages only: Hospital Indemnity, Critical Illness/Specified Disease, Retiree Medical (SMIP, GRIP, GRIP II) and (Standardized) Medicare Supplement, Prescription Drug coverage, Association Medicare Supplement, Medical Conversion Run-off, TRICARE and CHAMPVA Supplements and Long-Term Care.

Effective Date: This Notice was originally effective April 14, 2003 and as revised is effective March 10, 2022.

Uses and Disclosures of Your PHI

This section of the Notice explains how The Hartford uses and discloses your PHI with our employees, business associates, and other organizations as required or permitted by law without your authorization. We also require our business associates to protect the privacy of your PHI through written agreements with The Hartford. As explained below, we will request your written authorization in some instances to use or disclose PHI. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI as described herein, we will restrict our uses and disclosures of PHI in accordance with this more restrictive law.

Required Disclosures. The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate and/or determine The Hartford's compliance with HIPAA's privacy regulations.

Uses and Disclosures Related to Treatment, Payment and Healthcare Operations. The Hartford and/or its business associates may use and disclose PHI without your authorization or opportunity to agree or object for activities related to treatment, payment, and healthcare operations. In these instances, The Hartford will not request your authorization to share PHI. As described in the next section titled **Your Privacy Rights**, you have the right to request a restriction on the use and disclosure of your PHI for treatment, payment, or healthcare operations purposes. The Hartford may not use any PHI that is "genetic information" (as defined by the Genetic Information Nondiscrimination Act of 2008) for underwriting purposes. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities.

Examples of activities related to treatment include: treatment provided by a specialist who asks a primary care physician to share a patient's PHI.

Examples of activities related to payment include: payment of healthcare claims, determinations whether a member is eligible for healthcare coverage, or collection of premiums.

Examples of activities related to healthcare operations include: quality improvement; fraud and abuse prevention and detection;

case management and medical review; underwriting; and complaint resolution.

Uses and Disclosures of Your PHI That Do Not Require Your Authorization or Opportunity to Object. Your PHI may be disclosed without your authorization in the following circumstances: when required by law; public health activities; instances involving victims of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, as required or permitted by law; governmental health oversight activities (including audits, investigations, and inspections); judicial and administrative proceedings; certain law enforcement purposes; deceased persons to coroners, health examiners, and funeral directors; organ and tissue donation; certain government-approved research purposes; upon reasonable belief to avert a serious threat to health or safety; specialized government functions (such as military personnel, and inmates in correctional facilities); to individuals involved in your care or payment for your care; emergency treatment situations; disaster relief; or workers' compensation.

Use and Disclosures to Plan Sponsor. In some circumstances, The Hartford may also disclose PHI to the sponsor of your group health plan for plan administration functions.

Use and Disclosure to Contact You Regarding Health-Related Benefits and Services. The Hartford or its business associates may also contact you regarding health-related benefits and services that may be of interest to you.

Uses and Disclosures That Require Your Written Authorization. In all other circumstances not described above, uses and disclosures of your PHI will only be made with your written authorization. For example, we will need your authorization for the following circumstances:

- most uses or disclosures of psychotherapy notes;
- marketing communications; and
- disclosures that constitute a sale of PHI.

You may revoke such an authorization at any time, except to the extent The Hartford, its business associates, or other entities have relied on such disclosure.

Your Privacy Rights

This section of the Notice describes your rights as an individual with respect to your PHI and a brief description of how you may exercise these rights.

Right to Restrict Uses and Disclosures for Treatment, Payment and Healthcare Operations Purposes. You have the right to request that we restrict uses and disclosure of your PHI for activities related to treatment, payment and healthcare operations as described above. Your request for the restriction must be in writing. We will evaluate all requests for restrictions, however, we are generally not required to agree to the restriction. In certain circumstances, we may be obligated to honor your request for a restriction on disclosures to another health plan relating to a health care item or service for which you paid in full. If we agree to the restriction, we will abide by it, except in the case of emergency treatment or when required by law. We will terminate our agreement to a restriction if you agree to or request the termination of the restriction. If we decide to terminate our agreement to the restriction, we will notify you of our decision.

If you have paid for a health care item or service out-of-pocket and in full, you may request that we do not disclose to a health plan any PHI related solely to the item or service. We are obligated to honor that request unless we are required by law to make a disclosure.

Right to Request Confidential Communications. You may request that we communicate with you by alternative means or at alternative locations. For example, you may wish to receive communications from us at your work location rather than your home. We will evaluate all such requests, however, we must only accommodate your request if you clearly state that the communication of all or part of your PHI could endanger you.

Right to Inspect and Copy Your PHI. You have a right to access, inspect, and copy your PHI contained in a "designated record set" for as long as The Hartford maintains the PHI in the designated record set. Your right to access your PHI contained in a designated record set extends to any such information that is maintained in an electronic health record or another electronic form. However, you do not have an automatic right to access psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a criminal, civil or administrative action or proceeding. We will act on a request for access within 30 days of receiving your request if the information is maintained and accessible on site or within 60 days otherwise (with a possible 30-day extension). We will provide you with a summary of the PHI requested if you agree in advance to the summary and to the fees imposed.

We may deny your request to access your PHI under certain circumstances. If your request is denied, we will send you a notice that explains our reason for the denial, your review rights (if any), and how to file a complaint with our Privacy Officer or the Secretary of the Department of Health and Human Services. In certain instances we will provide you with an opportunity for a review of the denial. The review decision must be made in a reasonable period of time, and we will send you a written notice of the review decision. We may charge a reasonable fee for access, inspection and/or copying of your PHI. This fee is based on the costs associated with copying, mailing, and summary preparation costs.

Right to Amend Your PHI. You have the right to request that we amend your PHI if you believe the information is incorrect or inaccurate. We may deny your request to amend your PHI if we did not create the PHI, if the information is not part of our records, if the information was not available for inspection, or if the information is accurate and complete. We will respond to your written request to amend your PHI within 60 days of the request (with a possible 30-day extension).

If your request for amendment is granted, we will notify you that the amendment was approved. Upon your identification of relevant persons, we will obtain your agreement to inform them of the change. We will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you and by us, including our business associates.

If your request for the amendment is denied, we will send you a written notice that explains the reason for the denial, your right to submit a written statement of disagreement or to have the request for amendment included with future disclosures, and your right to file a complaint with our Privacy Officer and/or the Secretary of the Department of Health and Human Services.

We may prepare a rebuttal statement to your statement of disagreement. We will provide you with a copy of the rebuttal statement.

Any future disclosures of your PHI will include the statement of disagreement or request for amendment, the denial notice, and the rebuttal or summary of this information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your PHI made by The Hartford during the six years prior to the date of your request. We will act on your request for an accounting of disclosures within 60 days (with a possible 30-day extension).

This accounting of disclosures will not include disclosures made: prior to effective date of HIPAA, April 14, 2003; for treatment, payment, and healthcare operations; to you or your personal representative; pursuant to an authorization; for national security or intelligence purposes, as provided in regulations under HIPAA; to correctional institutions or law enforcement officials, as provided in regulations under HIPAA; incident to a use or disclosure permitted or required by law; and to persons involved in your care (if you were present), you were incapacitated, or for disaster relief purposes.

We will provide you with one free accounting each year. For subsequent requests, we will charge a reasonable fee. The written accounting of disclosures will include the following information for each disclosure: the date of the disclosure, the person to whom the information was disclosed, a brief description of the information disclosed or in lieu of the summary, a copy of the written request for the disclosure.

Right to be Notified Following a Breach. You have a right to be notified if there has been a breach involving your unsecured PHI.

Right to a Copy of Notice of Privacy Practices. You have the right to receive a paper copy of this Notice upon request, even if you agreed to receive the Notice electronically.

Complaints. You may file a complaint with The Hartford or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with The Hartford, contact the Consumer Rights and Privacy Compliance Unit at ConsumerPrivacyInquiriesMailbox@thehartford.com. We will not retaliate against you for filing a complaint.

Contact Information. If you have any questions about this Notice, or the subjects addressed in it including how to exercise your rights as set forth in this Notice, please contact the Consumer Rights and Privacy Compliance Unit at the email address above or call us at: 860-547-5000.

The Hartford's Duties

The Hartford will abide by the terms of this Notice of Privacy Practices.

The Hartford reserves the right to change its privacy practices and apply the changes to any PHI received or maintained by The Hartford prior to that date. If a privacy practice is materially changed, The Hartford will provide you with a revised Notice of Privacy Practices by mail or any other reasonable method of communication used to process or service your insurance or transactions with us.

**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 and Booklet are incorporated into, and form 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, to the extent permitted by applicable state law.

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

1. Plan Name

For employees of LIMRiCC:

Group Accident Plan

Group Critical Illness Plan

Group Hospital Indemnity Plan

2. Plan Number

Group Accident - 501

Group Critical Illness - 501

Group Hospital Indemnity - 501

3. Employer/Plan Sponsor

LIMRiCC
668 N. RIVER RD.
NAPERVILLE, IL 60563

4. Employer Identification Number

36-3997496

5. Type of Plan

Welfare Benefit Plan providing:

Group Accident Coverage

Group Critical Illness Insurance

Group Hospital Indemnity Coverage

6. Plan Administrator

LIMRICC
668 N. RIVER RD.
NAPERVILLE, IL 60563

7. Agent for Service of Legal Process

For the Plan

LIMRICC
668 N. RIVER RD.
NAPERVILLE, IL 60563

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 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

(Group Critical Illness Insurance, Group Accident Insurance and Group Hospital Indemnity Insurance) The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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

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

11. Labor Organizations

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, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

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 Insurance Company, 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 the Insurance Company receives 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) the specific reason or 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 Insurance Company's 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 the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) 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 your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

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, with the exception of an action under the deemed exhausted process described above. 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.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

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 the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

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, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment 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) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

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.