YOUR BENEFIT PLAN



Accidental Injury Benefits

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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. Please refer to your certificate for the requirements that impact the provisions included in 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 Claims Administrator for the Policy is:**
The Hartford **Group Benefits Division,** **Customer Service** **P.O. Box 2999** **Hartford, CT 06104-2999** **1-800-523-2233**	**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 Insurance Company 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.

NOTICES

- Arizona: If You are covered under a Policy issued to a trust group situsued outside of Arizona, the Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.
- Arkansas: 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: **For Your Questions and Complaints:**
  State of California Insurance Department
  Consumer Services Division
  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
- Florida:
  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.
- Idaho: For Your Questions and Complaints:
  Idaho Department of Insurance
  Consumer Affairs
  700 State Street, 3rd Floor
  PO Box 83720

Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

- 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.
- Illinois:
  You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

  This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:
  Illinois Department of Insurance
  320 W. Washington Street
  Springfield, Illinois 62767-0001

  Illinois Department of Insurance
  115 S. LaSalle Street
  13th Floor
  Chicago, Illinois 60603

  Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
  Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431
- Maryland:
  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 in the sections below will apply only to the extent that such state requirements are more beneficial to you.
- North Carolina:
  UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.
- Texas:

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

- Wisconsin: **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 (within Wisconsin)
1(608) 266-0103 (outside of Wisconsin)

- Virginia: **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)

CERTIFICATE FACE PAGE

- Massachusetts:



This Certificate alone does not meet the **Minimum Creditable Coverage standards** and will not satisfy the individual mandate that you have health insurance. Please see below for additional information.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

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

- New Hampshire: This is a Limited Policy - Read it Carefully
- New Hampshire: **This policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.**

BENEFIT SCHEDULE

- Maine: We will pay a minimum amount of $2,000 for covered losses due to accidental death or two or more dismemberments, if not already shown as an amount of $2,000 or more in the Benefit Schedule.
- Maine: We will pay a minimum amount of $1,000 for single dismemberments if not already shown as an amount of $1,000 or more in the Benefit Schedule.
- New Hampshire: We will pay a minimum amount of $1,000 for covered losses for one digit, $2,500 for covered losses for single dismemberments and $5,000 for two or more dismemberments and accidental death, if not already shown as these amounts or more in the Benefit Schedule.
- Texas: The Non-Insurance Services paragraph is removed.

DEFINITIONS

- South Dakota: The definitions of **Chiropractor, Dentist, Medical Professional, Physician**, and **Therapist** include Family Members if they are the only qualified provider of such service in the area and acting within the scope of their practice.
- South Dakota: The hourly time requirement, described in the **Confined, Confinement** definition, does not apply to Your coverage.

- Minnesota, Montana: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 25 unless shown as higher, provided Dependent Coverage is available under the Policy.
- New Hampshire, Utah: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 26, if not already shown as 26 and provided Dependent Child coverage is available under the Policy.
- New Hampshire: The unmarried Dependent Child requirement, described in the **Dependent Child(ren)** definition, does not apply, provided Dependent Child coverage is available under the Policy.
- New Hampshire, Utah: The student extension if shown in the **Dependent Child(ren)** definition does not apply, provided Dependent Child coverage is available under the Policy.
- Oregon: The definition of **Spouse**, if included in the **Definitions** section of the Certificate, is updated to include domestic partners, if not already shown in the definition.
- Utah: The disability extension in the **Dependent Child(ren)** definition is amended to require that the Dependent Child have a medically determinable physical impairment provided Dependent Child coverage is available under the Policy. In addition, proof of such impairment will only be required to be submitted annually after an initial 2 year period from the time the child has reached the limiting age.
- Montana: The definition of **Medical Professional** is revised to include the following list of practitioners: Physician, Dentist, osteopath, Chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, and licensed addiction counselor.
- Oregon: The definition of **Spouse** is amended to state the following: "Residents of Oregon in same-sex domestic partnerships are not required to demonstrate or prove their relationship through documentation or other requirements that are not also required for legal marriages."
- Montana: You have full freedom of choice in the selection of any health care provider for Treatment of an Accident within the health care provider's scope and limitations of practice, including: 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; speech language pathologist, audiologist, licensed addiction counselor or advanced practice registered nurse.

ELIGIBILITY AND EFFECTIVE DATES

- Utah: The **New Dependent Coverage** provision is amended to clarify that the date of acquisition is the date of birth for any newborn child placed with You for adoption within 30 days of birth.

REINSTATMENT OF COVERAGE

- Maine: The **Reinstatement of Coverage** provision includes the following:
  If the Employee/Member is a resident of the state of Maine and insurance ended due to the non-payment of premium, insurance may be reinstated within 90 days from the date insurance ended if the Insured/Member medically demonstrates that they suffered from cognitive impairment or functional incapacity at the time insurance ended. This demonstration must be submitted at the Employee's/Member's own expense and may be submitted by the Employee/Member, someone authorized to act on the Employee's behalf, or an insured Dependent.

CONTINUATION AND EXTENSION OF COVERAGE

- New Hampshire: The following **Extension of Coverage While Disabled** provision is added to the **Continuation and Extension of Coverage** section:
  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.

BENEFITS

- Montana: The requirement for receipt of Treatment in a Physician's or Medical Professional's office or clinic, if included in any of the benefits included in the **Benefits** section of the Certificate, is updated to include telehealth/telemedicine visits.

GENERAL LIMITATIONS & EXCLUSIONS

- Alaska: The extreme sports and activities exclusion, if included in the **Exclusions** provision, is limited to the specifically named sports and activities listed in the exclusion.
- Missouri: The suicide exclusion, if included in the **Exclusions** provision, is not applicable to suicide committed while the insured person is insane.

- Nevada, South Dakota: The voluntary intoxication and voluntary intoxication through use of poison, gas or fumes exclusions, if included in the **Exclusions** provision, does not apply to Your coverage.
- New Hampshire: The felony, incarceration, extreme sports and activities and use of illegal fireworks exclusions, if included in the **Exclusions** provision do not apply to Your coverage.
- New Jersey: The voluntary intoxication exclusion, if included in the **Exclusions** provision, is not applicable to being under the influence of a drug or controlled substance.
- New Jersey: Participation in a Riot, if cited in the **Exclusions** provision, is not applicable to Your coverage.

CLAIM PROVISIONS

- New Hampshire: The one year time limitation to provide proof of loss if unable to provide within the initial proof of loss period, as described in the **Proof of Loss** provision, does not apply to You.
- North Carolina: The initial proof of loss period, described in the **Proof of Loss** provision, is 180 days.
- Minnesota, North Carolina: The payment period, described in the **Time of Payment of Claims** provision, is immediately upon Our receipt of due Proof of Loss.

GENERAL PROVISIONS

- Alaska: The **Statements** provision is not applicable to statements made with the intent to defraud.
- New Hampshire, North Carolina: The **Time Limit on Certain Defenses** provision is not applicable to statements made with the intent to defraud.
- Alaska, Illinois, Kansas (for Policies not subject to ERISA only), Rhode Island, South Dakota, Texas, Vermont: The **Policy Interpretation** provision, if shown, is not applicable to Your coverage.

GROUP ACCIDENT INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see www.thehartford.com.

Policyholder: MAGNA INTERNATIONAL OF AMERICA, INC.
Policy Number: VAC-675847
Policy Effective Date: January 1, 2027
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 Delaware, 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. 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 current version of the Certificate for each Eligible Class included in the Policy replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. 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*

Michael J. Fish, *President*

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.

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

Notice to Buyer: Accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a covered Accident, subject to any limitations contained in the Policy. Coverage is NOT provided for basic hospital, basic medical-surgical or major medical expenses. Review Your Certificate carefully.

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 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 CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If a Covered Person is eligible for Medicare, they should review the Guide to Health Insurance for People with Medicare ("Medicare & You" handbook) available through www.medicare.gov/publications or from Us.

READ THIS CERTIFICATE CAREFULLY. The Primary Insured has a 30-day right from their 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)
Class 1 - All Full-Time Employees Subject to the 90 Day Eligibility Waiting Period as Determined by the Policyholder
Class 2 - All Full-Time Employees Subject to the 30 Day Eligibility Waiting Period as Determined by the Policyholder
Class 3 - All Full-Time Employees Not Subject to an Eligibility Waiting Period as Determined by the Policyholder

Coverage Type
24 hour – This Certificate provides coverage for Accidents that occur at any time, whether a Covered Person is working or during their free time, subject to all of the applicable requirements, maximums, limitations, Definitions, Exclusions and other provisions of the Policy.

Coverage Election
In order to be insured under the Policy an Employee must elect coverage for themself and any Dependent(s).

The Employee is required to pay premium for the coverage elected. Payment of premium does not guarantee eligibility for coverage.

Benefit Amounts Payable
The benefit amounts payable are shown in the Benefits Table that follows. Dependent benefit amounts are the same as Employee benefit amounts unless otherwise indicated in the table or by the applicable benefit provision in the Benefit(s) section of this Certificate.

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

BENEFITS TABLE

All benefits are subject to all of the applicable requirements, maximums, limitations, Definitions, Exclusions and other provisions of the Policy. The amounts shown below may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the Benefits and Exclusions sections of this Certificate.

Benefit:	**Benefit Amount:**
INITIAL & EMERGENCY CARE BENEFIT(S)	
Initial Accident	$200
Initial Medical Professional/Physician Visit	$300
Urgent Care	$300
Emergency Room (ER)	$300
Hospital Observation/Short Stay	$1,000
Ambulance	
Ground or Water	$1,000
Air	$2,000
X-Ray	$300
Diagnostic Exam	$750
FOLLOW-UP CARE BENEFIT(S)	
Follow-Up Medical Professional/Physician Visit	$300
Therapy Services	$150 per day
Chiropractic Care	$50 per day
Acupuncture	$50 per day
Home Health Services	$75 per day
Medical Travel	$400 per day
Companion Lodging	$150 per day
Follow-Up Medical Transportation/Rideshare	$75
Mobility Aid	
Brace	$200
Cane	$200

Benefit:	Benefit Amount:
Crutches	$200
Knee Walker	$250
Walker	$250
Walking Boot	$200
Wheelchair or Motorized Scooter	
Expected Use of Less Than One Year	$1,500
Expected Use of Greater Than One Year or Purchased	$2,500
Other Device for Mobility	$100
Prescription Drug	$25
Pain Management	
Surgical Nerve Block (Neurectomy)	$300
Epidural Injection	$300
Nerve Ablation (Radiofrequency Ablation (RFA))	$100
IV Infusion Therapy	$100
Local Nerve Block/Cortisone Injection	$100
Family Care	$50 per day
Pet Care	$50 per day
Health Screening or Accident Prevention	$75

ENHANCEMENT BENEFIT(S)

Organized Amateur Sports Injury	25%
Motor Vehicle Safety	25%

HOSPITAL/CONFINEMENT CARE BENEFIT(S)

Hospital Admission	$1,500
Hospital Confinement	$250 per day
Step Down Unit Confinement	$400 per day
Intensive Care Unit (ICU) Admission	$3,000
Intensive Care Unit (ICU) Confinement	$500 per day
Continuous Care Facility Confinement	$200 per day

SPECIFIC INJURY BENEFIT(S)

Brain Injuries	
Concussion/Moderate Brain Injury	$500
Burns (TBSA = Total Body Surface Area)	
Second Degree	
Less than 10% TBSA	$250
10-18% TBSA	$500
19-36% TBSA	$1,000
Greater than 36% TBSA	$1,500
Third Degree	
Less than 10% TBSA	$1,500
10-18% TBSA	$5,000
19-36% TBSA	$10,000
Greater than 36% TBSA	$20,000
Skin Graft (% of payable Burns Benefit)	50%
Dental Injuries	
Extraction	$150
Crown	$300
Dislocations	
Closed Reduction of Complete Dislocation	
Lower Jaw (Temporomandibular)	$500
Collarbone & Sternum (Sternoclavicular)	$500
Rib	$250
Collarbone & Shoulder (Acromioclavicular and separation)	$500
Shoulder (Glenohumeral)	$500
Elbow	$500
Wrist (Radiocarpal and/or intercarpal)	$500

Benefit:	Benefit Amount:
Hand (Carpometacarpal and/or intermetacarpal)	$500
Fingers (Interphalangeal and/or metacarpophalangeal)	$250
Hip	$4,000
Knee (Except kneecap/patella)	$1,500
Kneecap (Patella)	$500
Ankle (Talocalcaneal and/or talocalcaneonavicular)	$1,500
Foot (Tarsometatarsal and/or intermetatarsal)	$500
Toes (Interphalangeal and/or metatarsophalangeal)	$250
Incomplete Dislocation (% of applicable Closed Reduction amount)	25%
Open Reduction of Complete Dislocation	
Lower Jaw (Temporomandibular)	$1,000
Collarbone & Sternum (Sternoclavicular)	$1,000
Rib	$500
Collarbone & Shoulder (Acromioclavicular and separation)	$1,000
Shoulder (Glenohumeral)	$1,000
Elbow	$1,000
Wrist (Radiocarpal and/or intercarpal)	$1,000
Hand (Carpometacarpal and/or intermetacarpal)	$1,000
Fingers (Interphalangeal and/or metacarpophalangeal)	$500
Hip	$8,000
Knee (Except kneecap/patella)	$3,000
Kneecap (Patella)	$1,000
Ankle (Talocalcaneal and/or talocalcaneonavicular)	$3,000
Foot (Tarsometatarsal and/or intermetatarsal)	$1,000
Toes (Interphalangeal and/or metatarsophalangeal)	$500
Eye Injuries	
Object Removal	$200
Surgical Repair	$500
Fractures	
Closed Reduction	
Skull - Depressed (Cranial bones)	$4,000
Skull - Non-Depressed (Cranial bones)	$2,000
Bones of Face (Except nose and lower jaw)	$750
Nose (Nasal bones)	$750
Lower Jaw (Mandible)	$750
Collarbone (Clavicle)	$750
Breastbone (Sternum)	$2,000
Rib	$300
Shoulder (Scapula)	$1,000
Upper Arm (Humerus)	$1,200
Forearm (Radius and ulna)	$2,500
Wrist (Carpals)	$1,200
Hand (Metacarpals, except fingers)	$1,200
Fingers (Phalanges)	$1,000
Vertebral Body (Except vertebral processes)	$750
Vertebral Process	$750
Tailbone (Coccyx)	$500
Pelvis (Except tailbone and hip bones)	$4,000
Hip (Ilium, ischium and pubis)	$4,000
Thigh (Femur)	$4,000
Kneecap (Patella)	$750
Lower Leg (Tibia and fibula)	$1,000
Ankle (Talus)	$750
Foot (Metatarsals and calcaneus, except toes)	$1,000
Toes (Phalanges)	$1,000
Chip Fracture (% of applicable Closed Reduction amount)	25%

Benefit:	Benefit Amount:
Open Reduction	
Skull - Depressed (Cranial bones)	$8,000
Skull - Non-Depressed (Cranial bones)	$4,000
Bones of Face (Except nose and lower jaw)	$1,500
Nose (Nasal bones)	$1,500
Lower Jaw (Mandible)	$1,500
Collarbone (Clavicle)	$1,500
Breastbone (Sternum)	$4,000
Rib	$600
Shoulder (Scapula)	$2,000
Upper Arm (Humerus)	$2,400
Forearm (Radius and ulna)	$5,000
Wrist (Carpals)	$2,400
Hand (Metacarpals, except fingers)	$2,400
Fingers (Phalanges)	$2,000
Vertebral Body (Except vertebral processes)	$1,500
Vertebral Process	$1,500
Tailbone (Coccyx)	$1,000
Pelvis (Except tailbone and hip bones)	$8,000
Hip (Ilium, ischium and pubis)	$8,000
Thigh (Femur)	$8,000
Kneecap (Patella)	$1,500
Lower Leg (Tibia and fibula)	$2,000
Ankle (Talus)	$1,500
Foot (Metatarsals and calcaneus, except toes)	$2,000
Toes (Phalanges)	$2,000
Lacerations	
Treated without Laceration Repair Method	$100
Treated with Laceration Repair Method	
Less than 2 inches (5.08 cm)	$500
2 inches to 6 inches (5.08 cm to 15.24 cm)	$2,000
Greater than 6 inches (15.24 cm)	$5,000
Other Injury(ies)	
Ear Injury	$250
Gunshot Wound	$500
Puncture Wound	$100

SURGERY BENEFIT(S)

Exploratory Surgery or Debridement	$150
Minimally Invasive (Scope-Based) Surgery	$500
Abdominal, Cranial or Thoracic Surgery	$3,000
Hernia Repair	$500
Herniated Disc Repair	$1,000
Joint Replacement	$2,500
Knee Cartilage Repair	$3,000
Other Non-Specified Surgery	$500
Tendon, Ligament or Rotator Cuff Repair	
One Repair	$1,000
Two or More Repairs	$2,000
Outpatient Surgery Facility Fee	$150
Blood Products	$500
General Anesthesia	$150

CATASTROPHIC BENEFIT(S)

Death	
Basic Death	
Employee	$50,000
Spouse	$25,000

Benefit:	Benefit Amount:
Dependent Child(ren)	$13,000
Common Carrier Death	
Employee	$150,000
Spouse	$75,000
Dependent Child(ren)	$40,000
Transportation of Remains	$2,000
Dismemberment/Functional Loss	
Basic Dismemberment/Functional Loss	
Partial Finger or Partial Toe	$250
One Finger or One Toe	$500
Two or More Fingers or Toes	$2,000
One Hand or One Foot	$25,000
One Arm or One Leg	$25,000
Loss of Sight of One Eye	$25,000
Loss of Hearing of One Ear	$25,000
Catastrophic Dismemberment/Functional Loss	
One Hand and One Foot	$50,000
Both Hands or Both Feet	$50,000
One Arm and One Leg	$50,000
Both Arms or Both Legs	$50,000
Loss of Sight of Both Eyes	$50,000
Loss of Hearing of Both Ears	$50,000
Loss of Speech	$50,000
Paralysis	
One Limb (Monoplegia or Uniplegia)	$10,000
Two Limbs (Diplegia, Hemiplegia or Paraplegia)	$25,000
Three or Four Limbs (Triplegia or Quadriplegia)	$50,000
Other Catastrophic Benefits	
Coma	$10,000
Prosthetic Device	
One Device	$1,500
Two or More Devices	$3,000
Reasonable Modifications - Residence or Vehicle	$5,000

DEFINITIONS

The terms listed below will have the meanings set forth below for purposes of this Certificate. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Accident or Accidental 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 or death.

Accident Prevention Screening Test or Program means any of the following:

1) a dental exam, eye exam or hearing exam conducted by a Physician or Medical Professional;
2) an annual physical, sports physical or well child exam conducted by a Physician or Medical Professional;
3) an employer-sponsored wellness or biometric screening;
4) a serum cortisol test (for stress levels); or
5) successful completion of an appropriately licensed or accredited:
    a) emotion management or stress reduction program;
    b) driver safety and training program;
    c) motorcycle safety and training program; or
    d) workplace safety and training program.

Acupuncture means an alternative therapy that involves insertion of needles into targeted areas of the body by a licensed practitioner (an acupuncturist) to alleviate pain or treat various health conditions. Acupuncture does not include massage therapy, care for chronic conditions or other conditions not related to a Covered Injury.

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

1) performing all the regular duties of their 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 their regular scheduled workday (e.g., vacation or holiday) as long as the Employee was actively working on their 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.

Allergic Occurrence means the process or event by which an allergen contacts a Covered Person's body. Occurrences that may be Accidental relevant to Allergic Reactions include:

1) a specific event involving the application of force external to the body, such as a bee sting;
2) inhalation of a solid, liquid or gas on a specific occasion;
3) ingestion of a solid, liquid, gas or fungus on a specific occasion; or
4) absorption of a chemical through the skin on a specific occasion.

Allergic occurrences do not include:

1) acute or chronic exposure to any hazardous or toxic chemical or substance; or
2) the inhalation, ingestion or contraction of any virus, bacteria, protozoan organism or fungus.

Allergic Reaction means the overreaction of a Covered Person's immune system to a normally harmless substance known as an allergen requiring Treatment from a Physician or Medical Professional. Allergic reactions do not include:

1) rhinitis, atopy or similar underlying health conditions;
2) chronic inflammatory conditions, including asthma or exacerbations such as coughing, wheezing or shortness of breath;
3) allergic conditions, such as allergic rhinitis or allergic conjunctivitis;
4) idiopathic anaphylaxis; or
5) any allergic reaction for which the Allergic Occurrence is unknown or is not Accidental.

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

Blood Products means granulocytes, plasma, platelets, red blood cells or whole blood.

Burn means an Injury to flesh or skin caused by heat, electricity, chemicals, friction or radiation. A burn includes second and third degree burns in which damage penetrates to the dermis (the underlying layers of the skin). A burn does not include a sunburn or a first degree (superficial) burn of the epidermis (the outer layer of the skin).

Certificate means this document, that 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;
2) You and Your Spouse divorce;
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 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.

Chemical Element means a hazardous or toxic chemical to which a Covered Person is exposed on an acute, short-term basis through inhalation, ingestion or direct contact with the chemical.

This definition does not include:

1) exposure to radiation as the result of a "nuclear incident" or "nuclear accident" as defined by the International Atomic Energy Agency (IAEA);
2) any "chemical weapon" as defined by Organisation for the Prohibition of Chemical Weapons (OPCW) through Article II of the Chemical Weapons Convention (as amended);
3) any warfare or terrorism agent as identified by the Agency for Toxic Substances and Disease Registry (ATSDR); or
4) any bioterrorism agent or disease as identified by the Centers for Disease Control and Prevention (CDC).

Chip Fracture means a fragment or small piece of bone that has broken off near a joint at a place where a ligament is usually attached. A chip fracture is also known as an avulsion fracture. A chip fracture does not include a stress fracture or a hairline fracture.

Chiropractic Care means spinal manipulation services provided by a Chiropractor to correct a structural imbalance. Chiropractic care does not include massage therapy, care for chronic conditions or other Injuries not related to structural imbalance.

Chiropractor means a person who is appropriately licensed to practice and provide Chiropractic Care focused on the diagnosis and Treatment of neuromuscular disorders, with an emphasis on Treatment through manual adjustment and/or manipulation of the spine. The chiropractor must be acting within the scope of their license. A chiropractor does not include a Covered Person or any Family Member.

Closed Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment without Surgery. Closed reduction includes immobilization.

Coma or Comatose means a profound stupor or state of complete and total unconsciousness with no reaction to external stimuli or response to internal needs, that is diagnosed by a Physician with a Glasgow Coma Scale score of 8 or less (or equivalent), for which intubation is required for respiratory assistance. A coma does not include a coma that is the result of any alcohol or drug use.

Common Carrier means a method of common public transport with defined published routes, time schedules and rates approved by regulators. A common carrier includes public airlines, railroads, subways, trolleys, boats and bus lines. A common carrier does not include taxis, limousines, any privately chartered mode of transportation or any mode of transportation owned, operated or leased for or by the Policyholder.

Complete Dislocation means a complete, abnormal separation of a joint. A complete dislocation is also known as a luxation.

Concussion means a mild traumatic brain injury (MTBI) that temporarily affects brain function and is caused by a sudden impact to the head or a violent shaking of the head and body, with a Glasgow Coma Scale score of 13 or above (or equivalent).

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 20 consecutive hours.

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

Continuous Care Facility means a Hospice Facility, Rehabilitation Facility or Skilled Nursing Facility.

Conventional Firearm means a portable gun that fires a shot (bullet) driven by high-pressure gas produced through combustion of propellant (gunpowder) within an ammunition cartridge.

Covered Injury means an Injury that is the direct result of an Accident that is not excluded or limited by any other provision of the Policy. If a Covered Person is unavoidably exposed to the elements of nature or one or more Chemical Elements as the result of an Accident that results in one or more Injuries or Illness, such Injuries and Illness that are a direct result of the exposure will be deemed to be covered injuries that have occurred as the result of the Accident.

If a Covered Person experiences an Allergic Reaction that results in death or one or more Injuries or Illness, such death, Injuries or Illness that are a direct result of the Allergic Reaction will be deemed to be covered injuries that have occurred as the result of an Accident if:

1) the allergen can be definitively identified; and
2) the Allergic Occurrence is Accidental.

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 (ADLs) not requiring the constant attention of medical personnel, including the self-administration of medication.

Debridement or Debridement Procedure means a minimally invasive Surgical Procedure performed to treat or repair a Covered Injury through removal or modification of damaged cartilage or bone. A debridement procedure includes cartilage shaving and trimming.

Dentist means a person who is appropriately licensed to practice dentistry. The dentist must be acting within the scope of their license. A dentist does not include a Covered Person or any Family Member.

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

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);
3) a child for whom the Employee or Spouse is ordered by a court or administrative order to provide coverage regardless of whether they are 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 their disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Diagnostic Exam means any of the following major/advanced tests: bone scintigraphy, CT/CAT, DTI, EEG, MRI/MRA, PET, SPECT or ultrasound. This definition does not include any X-Ray.

Dislocation means Complete Dislocation and Incomplete/Partial Dislocation. A dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Dismemberment means the complete severance of a body part from the body as a result of trauma, prolonged constriction, or Surgery (amputation), as follows:

1) Finger – A finger is permanently severed at or above the metacarpophalangeal joint (the joint where the finger is attached to the hand). Severance of part of a finger at the proximal interphalangeal joint (the joint in the middle of

the finger) or the distal interphalangeal joint (the joint closest to the tip of the finger) is considered a partial finger dismemberment. For purposes of this definition, the thumb is a finger.
2) Toe – A toe is permanently severed at or above the metatarsophalangeal joint (the joint where the toe is attached to the foot). Severance of part of a toe at the proximal interphalangeal joint (the joint in the middle of the toe) or the distal interphalangeal joint (the joint closest to the tip of the toe) is considered a partial toe dismemberment.
3) Hand – A hand is permanently severed at or above the wrist joint.
4) Foot – A foot is permanently severed at or above the ankle joint.
5) Arm – An arm is permanently severed at or above the elbow.
6) Leg – A leg is permanently severed at or above the knee.

Eligible Family Member means:
1) a Dependent Child age 12 or younger; or
2) a mentally or physically disabled Family Member, regardless of age, who is living with a Covered Person and is dependent on the Covered Person for support and maintenance.

Eligible Pet means a domestic animal that is living with an adult Covered Person and is dependent on the adult Covered Person for care and maintenance.

Eligibility Waiting Period means the period of time an Employee must be a member in an Eligible Class before they are 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 or a Hospital Observation Unit.

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.

Epidural Injection means an injection of prescribed drug into the space around the spinal cord, also known as the epidural space, to provide relief from pain.

Exploratory Surgery means a Surgical Procedure, including scope-based diagnostic procedures (such as arthroscopy, laparoscopy, thorascopy or any other endoscope-aided procedure), that is performed for diagnostic purposes without repair of a Covered Injury.

Family Care means care provided for an Eligible Family Member on a regular basis for daily periods of less than 24 hours (whether daytime or nighttime hours).

Family Care Center means an appropriately licensed independent childcare or adult day care provider or facility that provides care for children or disabled adults in a group setting that is not owned or operated by a Covered Person or a Family Member.

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; 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.

Fracture means a break in a bone that can be detected by X-Ray or a similar Diagnostic Exam. A fracture does not include a Chip Fracture, a stress fracture or a hairline fracture.

Functional Loss means any of the following:

1) Loss of Hearing – Permanent loss of hearing in an ear with an aided hearing loss range of 71 decibels (dB HL) or higher (unable to hear sound at or below 70 dB HL) that cannot be improved or corrected to any greater functional degree by any aid, procedure or device.
2) Loss of Sight – Permanent loss of sight in an eye with no realistic expectation of improvement, or severance of an eye. With best correction of an eye, visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees.
3) Loss of Speech – Total and permanent loss of audible voice communication that cannot be corrected to any functional degree by any aid, procedure or device.

General Anesthesia means the administration of one or more general anesthetic agents, administered intravenously or inhaled, to induce a state of unconsciousness accompanied by:

1) loss of protective reflexes;
2) loss of the ability to maintain an airway independently; and
3) inability to respond purposefully to physical stimulation or command.

Guaranteed Issue means the amount of insurance We may issue without a health application or other proof of good health.

Health Screening Test means any of the following screening tests recommended or prescribed by a Physician or Medical Professional and conducted in a clinical setting: 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; 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); thermography; or any other generally medically accepted screening test.

Helmet means a protective device worn on the head that at a minimum meets the DOT helmet standard (Federal Motor Vehicle Safety Standard 218 (as amended)) for which the helmet is labeled as required by the DOT.

Herniated Disc means a tear in the outer, fibrous ring (annulus fibrosus) of an intervertebral disc (discus intervertebralis) enabling the inner portion (nucleus pulposus) to herniate or extrude through the damaged outer rings. A herniated disc does not include a bulging disc. A common name for a herniated disc is a ruptured disc.

Homebound means a person is unable to or has trouble leaving their residence without help from any durable medical equipment or another person because of a medical condition.

Home Health Care Agency means an appropriately licensed home health care agency that:

1) is primarily engaged in providing Home Health Services;
2) provides services under the supervision of a Physician or Medical Professional;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) maintains clinical records on all patients.

Home Health Services means healthcare services provided by a Home Health Care Agency in the residence of a person, including but not limited to: counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

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

Hospice Care means specialized care, medical services and emotional support for a person who is in the last stages of life, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, that:

1) provides Hospice Care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3) is not mainly a place for care of the aged/elderly, care of persons with Substance Use Disorders, care of persons with Mental Health Disorders, or a hotel or similar establishment.

Confinement in a hospice facility must follow certification by a Physician or hospice medical director that a Covered Person is terminally ill with less than 6 months to live. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

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; 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 rehabilitory care; or
3) facilities primarily for care of the aged/elderly, care of persons with Substance Use Disorders, or care of persons with mental health disorders.

Illness means:

1) a physical disease, disorder, illness or infirmity (including medical or surgical Treatment thereof), except for Allergic Reactions as specifically allowed by this Certificate;
2) a mental health disorder or Substance Use Disorder;
3) pregnancy or childbirth; and
4) infection, except for infection that is the natural result of a Covered Injury.

Incomplete Dislocation means a joint is misaligned but not completely separated. An incomplete dislocation is also known as a subluxation or partial dislocation.

Injury or Injuries means bodily damage or harm that must be independent of Illness or any other cause and requires Treatment by a Physician or Medical Professional.

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.

This definition does not include any Step Down Unit or Observation Unit, or any private monitored room.

IV Infusion Therapy means the administration of a prescribed drug through a needle or catheter to provide relief from pain that occurs on an Outpatient basis.

Laceration means a cut or tear of the skin or flesh.

Laceration Repair Method means sutures (stitches), staples, skin closure strips or tissue adhesive (glue).

Local Nerve Block/Cortisone Injection means the injection of a combination of a local anesthetic, epinephrine, cortisone (corticosteroid) and/or an opioid onto or near a nerve or into a joint to provide relief from pain that occurs on an Outpatient basis. This definition does not include an Epidural Injection.

Local Transportation means transportation provided by a taxi, rideshare (e.g., Uber or Lyft) or professional car service to the general public in exchange for a fee that is not owned or operated by a Covered Person or a Family Member.

Lodging means an appropriately licensed establishment, such as a hotel, inn, lodge, motel or other facility that provides sleeping accommodations to the general public in exchange for a fee that is not owned or operated by a Covered Person or a Family Member.

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 their license. A medical professional does not include a Covered Person or any Family Member.

Minimally Invasive (Scope-Based) Surgery means a minimally invasive Surgical Procedure that is completed through one or more small incisions and assisted with an endoscope and other special instruments, including arthroscopy, laparoscopy and thorascopy, that is performed to repair a Covered Injury. Minimally invasive (scope-based) surgery does not include Exploratory Surgery or Debridement.

Moderate Brain Injury means a brain injury caused by a sudden impact to or penetration of the head resulting in a loss of consciousness from 20 minutes to 6 hours with a Glasgow Coma Scale score of 9 to 12 (or equivalent).

Mobility Aid means an appliance or device that is intended by its manufacturer to assist a person with personal locomotion or mobility due to a malfunctioning part of the body, including (but not limited to) the appliances/devices listed in the Benefit Schedule.

A mobility aid does not include:

1) modifications to a Covered Person's place of residence, property or automobile(s), including but not limited to ramps, lifts, elevators, spas or vehicle hand controls; or
2) exercise or sports equipment.

Motor Vehicle means any vehicle with two to four wheels powered by an internal combustion engine and/or electric motor that is appropriately registered for use on public roadways, including:

1) automobiles (cars, trucks, vans or sport utility vehicles (SUVs);
2) motorcycles or low-power cycles (scooters or mopeds); or
3) recreational vehicles (RVs), motor homes or campers, which include living quarters designed for accommodation.

This definition does not include farm equipment; all-terrain vehicles; recreational off-highway vehicles (ROVs, including "side-by-sides" and utility task vehicles (UTVs)); off-road motorcycles; or any vehicle that is being used in a Common Carrier capacity.

Nerve Ablation (Radiofrequency Ablation (RFA)) means a nonsurgical, minimally invasive procedure that uses heat to stop or reduce the transmission of pain through the use of radiofrequency waves to ablate (burn) the nerve that is causing the pain that occurs on an Outpatient basis.

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.

Open Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment with Surgery.

Open Surgery means a Surgical Procedure wherein internal tissues and structures are exposed through an incision to the air and the surgeon has direct sight of the damaged area. Open surgery does not include Exploratory Surgery, Debridement or Minimally Invasive (Scope-Based) Surgery.

Organized Amateur Sport Activity means an athletic event occurring on a sports field or at a sports venue, including scheduled practices, games and related events that are:

1) associated with organized school programs; or

2) governed by an organization for which formal registration is required to participate and formal rules are established;

in which participants engage without remuneration or payment.

This definition does not include:

1) any unscheduled activity, such as unstructured/spontaneous play or pick-up games; or
2) any athletic event or activity for which a Covered Person receives payment for participation in the event/activity.

Outpatient means Treatment or services received at a Hospital, ambulatory surgical center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility for which the recipient of the Treatment or services is not Confined.

Pain Management Method means any of the pain management methods listed in the Benefits Schedule, as defined in this Definitions section.

Paralysis means the total, permanent and irreversible loss of use of one or more limbs without severance.

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.

Pet Boarding Facility means an appropriately licensed independent animal care provider or facility specializing in the care and overnight or long-term boarding of animals that is not owned or operated by a Covered Person or a Family Member.

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 their 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.

Prescription Drug means a pharmaceutical substance that legally requires a medical prescription to be dispensed. This definition does not include:

1) any drug that is available over the counter or for which a suitable equivalent drug is available over the counter; or
2) immunizations, biological sera or Blood Products.

Primary Insured means an Employee who is currently insured under the Policy and this Certificate. (See also You, Your.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

Prosthetic Device means an artificial device that replaces a missing body part. A prosthetic device does not include auditory implants or hearing aids, dental aids (including dentures/false teeth), eyeglasses, cosmetic prostheses (such as wigs) or joint replacements (such as an artificial hip or knee).

Puncture Wound means an Injury caused by:

1) a small object, such as a nail or a needle, that pierces or penetrates the skin, creating a small hole in the surface of the skin; or
2) a knife or similar pointed object that penetrates the skin and enters a tissue of the body creating an open wound, also known as a stab wound.

Reasonable Modifications means:

1) internal or external structural modifications to a Covered Person's primary residence to make it accessible for the Covered Person, including (but not limited to):
   a) widening of door frames or replacement doors;
   b) addition of ramps, stairs or handrails; or
   c) modifications to walkways; or

2) modification to or installation of assistive devices for one automobile (car, truck, van or SUV) to make it drivable or rideable for a Covered Person.

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable a person who has experienced a disabling illness or Injury to achieve the highest possible functional ability.

Rehabilitation Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, that:

1) provides Rehabilitation Care Services;
2) is under the direct supervision of a Physician;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Use Disorders, care of persons with Mental Health Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Seat Belt means:

1) a manufacturer installed lap and/or shoulder restraint, or proper replacement restraints installed to the vehicle manufacturer's specifications, that meets published federal safety standards; or
2) a child restraint device that meets current National Safety Council standards and is installed according to manufacturer recommendations for children of like age and weight.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, that:

1) provides skilled nursing care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Use Disorders, care of persons with Mental Health Disorders, or a hotel or similar establishment.

Confinement in a skilled nursing facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Skin Graft means a Surgical Procedure by which skin, skin stem cells or skin substitute is placed over a Burn to permanently replace damaged or missing skin, or to regenerate damaged or missing skin.

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

Step Down Unit means a unit within a Hospital intended for patients who require intermediate care – close observation, Treatment and nursing care that cannot be provided in a general ward/room, but whose care is not critical enough to warrant an ICU bed – including:

1) a high dependency unit or transitional high dependency unit;
2) an intensive recovery unit;
3) an intermediate care unit;
4) a modified care unit or moderate care unit;
5) a pre- or post-intensive care unit;
6) a progressive care unit;
7) a step down unit;
8) a sub-acute intensive care unit; or
9) a transitional care unit.

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

Surgery or Surgical Procedure means a medical procedure requiring an incision to the skin or tissue and manipulation (typically with instruments) performed on a person's body to diagnose or repair a Covered Injury.

Surgical Nerve Block (Neurectomy) means a type of nerve block involving a surgical procedure to sever or remove a nerve. This procedure is typically performed in rare cases of severe or chronic pain where no other Treatments have been successful.

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

Therapy Services means cognitive behavioral therapy (for Accident-induced PTSD), occupational therapy, physical therapy, respiratory therapy, speech therapy, therapeutic counseling or vocational therapy.

Total Body Surface Area (TBSA) means an assessment of the area of Injury of a Burn in comparison with the entire surface area of the body as determined by a Physician via one of the following methods:

1) the Rule of Nines;
2) the Lund and Browder Chart; or
3) the Covered Person's palm.

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 (ER), 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.

Written or Writing means a record or information that may be transmitted by paper or electronic media in accordance with applicable law.

X-Ray means a form of electromagnetic radiation that passes through structures within the body and results in images of the structures. This definition does not include any Diagnostic Exam.

You, Your means an Employee who is currently insured under the Policy and this Certificate. (See also Primary Insured.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

ELIGIBILITY & 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 they become a member of an Eligible Class; or
3) the date they complete 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) no 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 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, they are 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:
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.

New Dependent Coverage
If You:
1) marry; 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 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:
1) under a Continuation provision; or
2) under the Extended Continuation provision.

Termination of coverage has no effect on benefits payable for an Accident or a Covered Injury that occurred 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 within 31 days from their 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.

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 Extended Continuation provision, unless such coverage is cancelled or surrendered.

CONTINUATION

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 Option(s) 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 Option(s);
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 1 months from the date You ceased Active Work.

Federal 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 or state laws.

Disability Insurance: If You are not Actively at Work and are approved for or are receiving benefits through a group disability insurance policy or plan maintained or sponsored by the Policyholder and issued or administered by Us, coverage may be continued for as long as You are receiving disability benefits, but in no event more than 6 months from the date You ceased Active Work.

Layoff: If You are subject to a temporary involuntary layoff by the Policyholder, coverage may be continued for up to 1 months from the date You ceased Active Work. If the layoff becomes permanent, this continuation will cease immediately.

EXTENDED CONTINUATION

Extended Continuation
You or an insured Spouse, in certain circumstances, may continue coverage under the Policy when insurance would otherwise end under the Termination of Coverage provision.

You may be able to continue coverage for You and any insured Dependent(s) under this provision when You:

1) are no longer Actively at Work and are not eligible for coverage under any other Continuation provision in this Certificate; or
2) are no longer employed by the Policyholder, including retirement.

If You are eligible to continue coverage under this provision, then You must elect insurance under this provision in order for any Dependent(s) to remain eligible for coverage.

An insured Spouse may be able to continue coverage under this provision for themself and any insured Dependent Child(ren):

1) in the event of Your death;
2) in the event of divorce 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 continues coverage under this provision, the Spouse will become a Primary Insured going forward. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

Requesting Extended Continuation
When coverage under the Policy would otherwise end, notice of the right to continue coverage under this provision will be given. To elect Extended Continuation, You or Your insured Spouse must send a request to Us.

The request and the initial premium due must be received within 31 days after insurance under the Policy would otherwise end. If timely notice is not given, an extension of the period of time in which to request continued coverage under this provision will be allowed. You or Your Spouse will have 15 days from the date notice is received to submit the 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.

Coverage continued under this provision:

1) will become effective on the first day of the month following the date coverage under the Policy would otherwise end, so that there is no interruption in coverage; and
2) is subject to continued payment of premium as due.

Coverage continued under this provision will end on the last day of the month during which You resume Active Work for 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.

BENEFITS

All benefits are subject to all of the applicable requirements, maximums, limitations, Definitions, Exclusions and other provisions of the Policy. The Benefit Amounts shown in the Benefit Schedule may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the following provisions. Please read all sections of the Certificate carefully in order to fully understand each benefit.

Benefits are only payable for an Accident that occurs while a Covered Person is insured under the Policy. We will not pay benefits for an Accident that occurred prior to a Covered Person's effective date of coverage under the Policy.

INITIAL & EMERGENCY CARE BENEFITS

Initial Accident Benefit
We will pay the Initial Accident Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries and is unable to immediately provide Proof of Loss to validate a claim for benefits under the Policy.

This benefit is payable once per Accident for each Covered Person. The amount of any future benefits payable for a Covered Person for the same Accident will be reduced by the Initial Accident Benefit Amount paid, after providing Proof of Loss.

Initial Medical Professional/Physician Visit Benefit
We will pay the Initial Medical Professional/Physician Visit Benefit Amount shown in the Benefit Schedule if a Covered Person receives initial Treatment following an Accident for one or more Covered Injuries from a Physician or Medical Professional in such individual's office or clinic.

The Treatment must occur within 30 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Urgent Care Benefit
We will pay the Urgent Care Benefit Amount shown in the Benefit Schedule if a Covered Person receives Treatment in an Urgent Care Facility as the result of one or more Covered Injuries.

The Treatment must occur within 30 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Emergency Room (ER) Benefit
We will pay the Emergency Room (ER) Benefit Amount shown in the Benefit Schedule if a Covered Person receives Treatment in an ER as the result of one or more Covered Injuries.

The Treatment must occur within 3 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Hospital Observation/Short Stay Benefit
We will pay the Hospital Observation/Short Stay Benefit Amount shown in the Benefit Schedule if a Covered Person receives Treatment as the result of one or more Covered Injuries in a Hospital (including an Observation Unit) for:

1) a period of less than 20 consecutive hours; or
2) a period of 20 consecutive hours or more without a charge for room and board.

The Treatment must occur within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit will not be paid for any day for which any Confinement benefit is payable.

Ambulance - Air Benefit
We will pay the Ambulance - Air Benefit Amount shown in the Benefit Schedule if a Covered Person is transported via air by a licensed professional ambulance company to a Hospital or between medical facilities for Treatment of one or more Covered Injuries.

The ambulance transportation must occur within 3 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Ambulance - Ground or Water Benefit
We will pay the Ambulance - Ground or Water Benefit Amount shown in the Benefit Schedule if a Covered Person is transported via ground or water by a licensed professional ambulance company to a Hospital or between medical facilities for Treatment of one or more Covered Injuries.

The ambulance transportation must occur within 30 days after the Accident. This benefit is payable once per Accident for each Covered Person.

X-Ray Benefit
We will pay the X-Ray Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes an X-Ray for the purpose of diagnosing one or more Covered Injuries.

The X-Ray must occur within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Diagnostic Exam Benefit
We will pay the Diagnostic Exam Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes a Diagnostic Exam for the purpose of diagnosing one or more Covered Injuries.

The exam must occur within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

FOLLOW-UP CARE BENEFITS

Follow-Up Medical Professional/Physician Visit Benefit
We will pay the Follow-Up Medical Professional/Physician Visit Benefit Amount shown in the Benefit Schedule if a Covered Person receives follow-up Treatment from a Physician or Medical Professional in such individual's office or clinic as the result of one or more Covered Injuries.

The Treatment must occur within 365 days after the Accident. This benefit is payable up to 3 times, per Accident for each Covered Person.

This benefit is not payable for routine examinations, immunizations, Acupuncture, Chiropractic Care or Therapy Services.

Therapy Services Benefit
We will pay the Therapy Services Benefit Amount shown in the Benefit Schedule if a Covered Person receives Therapy Services from a Therapist as the result of one or more Covered Injuries.

The therapy must be prescribed by a Physician or Medical Professional. All therapy Treatment must be rendered within 365 days after the Accident. This benefit is payable up to 10 times per Accident for each Covered Person.

Chiropractic Care Benefit
We will pay the Chiropractic Care Benefit Amount shown in the Benefit Schedule if a Covered Person receives Chiropractic Care from a Chiropractor in such individual's office or clinic as the result of one or more Covered Injuries.

The Chiropractic Care must be recommended or prescribed by a Physician or Medical Professional. All chiropractic Treatment must be rendered within 365 days after the Accident. This benefit is payable up to 10 times per Accident for each Covered Person, and is only payable once per day.

Acupuncture Benefit
We will pay the Acupuncture Benefit Amount shown in the Benefit Schedule if a Covered Person receives Acupuncture from an acupuncturist in such individual's office or clinic as the result of one or more Covered Injuries.

The Acupuncture must be recommended or prescribed by a Physician or Medical Professional. All Acupuncture Treatment must be rendered within 365 days after the Accident. This benefit is payable up to 10 times per Accident for each Covered Person, and is only payable once per day.

Home Health Services Benefit
We will pay the Home Health Services Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Homebound and receives Home Health Services as the result of one or more Covered Injuries.

The services must be prescribed by a Physician. Treatment must be rendered within 365 days after the Accident. This benefit is payable up to 10 days per Accident for each Covered Person.

Medical Travel Benefit
We will pay the Medical Travel Benefit Amount shown in the Benefit Schedule for each day a Covered Person must travel to or from a Hospital or other medical facility more than 100 miles away from their primary residence for Treatment as the result of one or more Covered Injuries.

The Treatment for which travel is required must be prescribed by a Physician and the same or similar Treatment must not be available within 100 miles of the Covered Person's primary residence. The travel must occur within 365 days after the Accident. This benefit is payable up to 4 times, per Accident for each Covered Person, and is only payable once per day.

This benefit will not be paid for any form of ambulance transportation. Proof of the expense incurred for the travel must be submitted with the claim. Mileage is measured as the distance from the Covered Person's primary residence to the facility at which the Treatment occurs.

Companion Lodging Benefit
We will pay the Companion Lodging Benefit Amount shown in the Benefit Schedule for each day an expense is incurred for Lodging by an adult Family Member or adult companion accompanying a Covered Person who is Confined more than 100 miles away from the Covered Person's primary residence for Treatment as the result of one or more Covered Injuries.

This benefit is payable up to 15 days per Accident for each Covered Person. This benefit is only payable:
1) once per day;

2) if the adult Family Member or adult companion is providing care for the Covered Person or is acting as an advocate on the behalf of a Covered Person while the Covered Person is receiving Treatment;
3) if a benefit for Confinement is payable for a Covered Person for the same day under the Policy; and
4) if the same or similar Treatment is not available within 100 miles of the Covered Person's primary residence.

Proof of the expense incurred for the Lodging must be submitted with the claim. Mileage is measured as the distance from the Covered Person's primary residence to the facility at which the Confinement occurs.

Follow-Up Medical Transportation/Rideshare Benefit
We will pay the Follow-Up Medical Transportation/Rideshare Benefit Amount shown in the Benefit Schedule if an expense is incurred by a Covered Person for Local Transportation within 100 miles of the Covered Person's primary residence to or from follow-up Treatment, Therapy Services, Chiropractic Care or Acupuncture received at an office, clinic or other medical facility as the result of one or more Covered Injuries.

The benefit is only payable if a Follow-Up Medical Professional/Physician Visit Benefit, Therapy Services Benefit, Chiropractic Care Benefit or Acupuncture Benefit is payable for the same day. This benefit is payable up to 3 times, per Accident for each Covered Person.

This benefit will not be paid for any form of ambulance transportation, or for any day for which the Medical Travel Benefit is payable. Proof of the expense incurred for the Local Transportation must be submitted with the claim. Mileage is measured as the distance from the Covered Person's primary residence to the office or clinic at which the follow-up Treatment occurs.

Mobility Aid Benefit
We will pay the applicable Mobility Aid Benefit Amount shown in the Benefit Schedule if a Covered Person requires the use of a Mobility Aid as the result of one or more Covered Injuries.

Any Mobility Aid must be prescribed or recommended by a Physician or Medical Professional, and be received within 365 days after the Accident.

If more than one Mobility Aid is received as a result of the Accident, the maximum benefit payable for the Accident is up to 200% of the highest applicable amount.

If We pay this benefit and subsequently an additional Mobility Aid is received as a result of the Accident for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount.

Prescription Drug Benefit
We will pay the Prescription Drug Benefit Amount shown in the Benefit Schedule if a Covered Person fills a prescription for a Prescription Drug through an appropriately licensed retail or mail order pharmacy for Treatment of one or more Covered Injuries.

The drug must be prescribed by a Physician or Medical Professional and received within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit will not be paid for any drug that is administered to or received by a Covered Person while Confined in any medical facility.

Pain Management Benefit
We will pay the applicable Pain Management Benefit Amount shown in the Benefit Schedule if a Covered Person receives pain management through a Pain Management Method as the result of one or more Covered Injuries.

The Pain Management Method must be prescribed by a Physician or Medical Professional and be received within 365 days after the Accident.

If more than one Pain Management Method is received as a result of the Accident, the maximum benefit payable for the Accident is up to 200% of the highest applicable amount. If We pay this benefit and subsequently an additional Pain Management Method is received as a result of the Accident for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount.

This benefit is only payable for Nerve Ablation, IV Infusion Therapy or Local Nerve Block/Cortisone Injections that occur on an Outpatient basis. This benefit will not be paid for any Pain Management Method:
1) administered to or received by a Covered Person while Confined in any medical facility; or

2) administered in relation to or during a Surgery, except for a Surgical Nerve Block that occurs independently of any other Surgical Procedure.

Family Care Benefit
We will pay the Family Care Benefit Amount shown in the Benefit Schedule for each day an expense is incurred for Family Care for one or more Eligible Family Members by an adult Covered Person who is Confined as the result of one or more Covered Injuries.

This benefit is payable up to 30 days per Accident for each adult Covered Person. This benefit is only payable:
1) once per day, regardless of the number of Eligible Family Members for which care is received;
2) for Family Care provided at a Family Care Center; and
3) for a day for which a Confinement benefit is payable for an adult Covered Person under the Policy.

An Eligible Family Member does not have to be insured under the Policy for this benefit to be payable. Proof of the expense incurred by an adult Covered Person for Family Care must be submitted with the claim.

Pet Care Benefit
We will pay the Pet Care Benefit Amount shown in the Benefit Schedule for each day an expense is incurred for the boarding of one or more Eligible Pets by an adult Covered Person who is Confined as the result of one or more Covered Injuries.

This benefit is payable up to 30 days per Accident for each adult Covered Person. This benefit is only payable:
1) once per day, regardless of the number of Eligible Pets for which boarding is received;
2) for overnight boarding provided at a Pet Boarding Facility; and
3) for a day for which a Confinement benefit is payable for an adult Covered Person under the Policy.

Proof of the expense incurred by an adult Covered Person for pet boarding must be submitted with the claim.

Health Screening or Accident Prevention Benefit
We will pay the Health Screening or Accident Prevention Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes a Health Screening Test or Accident Prevention Screening Test or Program.

This benefit is payable once per Policy 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 under the Policy.

ENHANCEMENT BENEFITS

Organized Amateur Sports Injury Benefit
We will pay the Organized Amateur Sports Injury Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries while participating in an Organized Amateur Sport Activity.

This benefit increases the benefits payable for an Accident, except for any Catastrophic Benefits, by the percentage shown in the Benefits Schedule up to a maximum of $2,000. Proof of registration or enrollment of a Covered Person with the school, organization or event associated with the activity during which the Accident occurs must be submitted with the claim.

Motor Vehicle Safety Benefit
We will pay the Motor Vehicle Safety Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries as a result of a Motor Vehicle Accident while wearing a properly fastened Seat Belt or Helmet.

This benefit increases the benefits payable for an Accident, except for any Catastrophic Benefits, by the percentage shown in the Benefits Schedule up to a maximum of $2,000. A copy of the police report for the Accident documenting the proper Seat Belt or Helmet usage by a Covered Person must be submitted with the claim.

This benefit will not be paid for a Covered Person if at the time of the Accident:
1) the Covered Person was breaking any laws of the jurisdiction in which the Accident occurred; or
2) a Seat Belt was used to restrain more than one person at the time of the Accident, including the Covered Person.

HOSPITAL/CONFINEMENT CARE BENEFITS

Hospital Admission Benefit
We will pay the Hospital Admission Benefit Amount shown in the Benefit Schedule if a Covered Person is admitted to a Hospital as an Inpatient as the result of one or more Covered Injuries.

The admission must occur within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable:
1) for Treatment in an Emergency Room (ER), on an Outpatient basis, in an Observation Unit or other observation area of a Hospital, or for a Hospital stay of less than 20 hours; or
2) if the Intensive Care Unit (ICU) Admission Benefit is payable for a Covered Person for the same Accident.

Hospital Confinement Benefit
We will pay the 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 one or more Covered Injuries.

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

This benefit is not payable for Treatment in an Emergency Room (ER), on an Outpatient basis, 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 applicable Confinement benefit is payable.

Step Down Unit Confinement Benefit
We will pay the Step Down Unit Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined to a Step Down Unit as the result of one or more Covered Injuries.

The initial period of Confinement for the Accident must begin within 90 days after the Accident. This benefit is payable for up to 30 days per Accident for each Covered Person. This benefit is only payable once per day, even if the Confinement is the result of more than one 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 applicable Confinement benefit is payable.

Intensive Care Unit (ICU) Admission Benefit
We will pay the ICU Admission Benefit Amount shown in the Benefit Schedule if a Covered Person is admitted to an Intensive Care Unit (ICU) as an Inpatient as the result of one or more Covered Injuries.

The admission must occur within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If more than one type of admission occurs for a Covered Person for the same Accident, only the highest applicable admission benefit is payable for that Accident.

Intensive Care Unit (ICU) Confinement Benefit
We will pay the 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 one or more Covered Injuries.

The initial ICU Confinement must begin within 90 days after the Accident. This benefit is payable for up to 15 days per Accident 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 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 applicable Confinement benefit is payable.

Continuous Care Facility Confinement Benefit
We will pay the Continuous Care Facility Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined to a Continuous Care Facility as an Inpatient as the result of one or more Covered Injuries.

Any period of Continuous Care Facility Confinement must begin within 30 days following a related Confinement in a Hospital for which benefits are payable under the Policy. This benefit is payable for up to 90 days per Accident for each Covered Person. This benefit is only payable once per day, even if the Confinement is the result of more than one 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 applicable Confinement benefit is payable.

SPECIFIC INJURY BENEFIT(S)

BRAIN INJURY

Concussion/Moderate Brain Injury Benefit
We will pay the Concussion/Moderate Brain Injury Benefit Amount shown in the Benefit Schedule if a Covered Person is diagnosed with a Concussion or Moderate Brain Injury as the result of an Accident.

The diagnosis of Concussion or Moderate Brain Injury must occur by a Physician or Medical Professional within 30 days after the Accident. This benefit is payable once per Accident, and up to 3 times per Policy Year, for each Covered Person.

BURNS

Burns Benefit
We will pay the applicable Burns Benefit Amount shown in the Benefit Schedule if a Covered Person receives Treatment for a Burn sustained as the result of an Accident. The benefit amount is based on the classification (size and severity) of the Burn, as diagnosed by a Physician or Medical Professional.

The initial Treatment of the Burn must occur by a Physician or Medical Professional within 3 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If the Burns sustained by a Covered Person as a result of the Accident meet more than one of the classifications shown in the Benefit Schedule, only the highest applicable benefit amount is payable.

Skin Graft Benefit
We will pay the Skin Graft Benefit Amount shown in the Benefit Schedule if a Covered Person receives a Skin Graft for a Burn for which a Burns Benefit is payable under the Policy. This benefit is payable once per Accident for each Covered Person.

DENTAL INJURIES

Extraction Benefit
We will pay the Extraction Benefit Amount shown in the Benefit Schedule if a Covered Person sustains damage to a sound natural tooth as the result of an Accident which results in extraction of the damaged tooth.

The extraction must occur by a Dentist within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Crown Benefit
We will pay the Crown Benefit Amount shown in the Benefit Schedule if a Covered Person sustains damage to a sound natural tooth as the result of an Accident which results in repair of the damaged tooth with a crown.

The crown placement must occur by a Dentist within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

DISLOCATIONS

Dislocations Benefit
We will pay the applicable Dislocations Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a Complete Dislocation or Incomplete Dislocation as the result of an Accident. The benefit amount for a Complete Dislocation is based on the type of Treatment received for the Dislocation.

If a Complete Dislocation is Treated without the use of anesthesia, the benefit amount payable is 25% of the applicable benefit amount shown in the Benefit Schedule.

The diagnosis of the Dislocation must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is only payable once per joint/joint group (as listed in the Benefit Schedule) for each Covered Person under the Policy.

If a Complete Dislocation is Treated with both Closed Reduction and Open Reduction, only the highest applicable benefit amount for that joint/joint group is payable. If a Dislocation of more than one joint/joint group is sustained as a result of the Accident, the maximum benefit payable is up to 200% of the highest applicable amount.

If both a Dislocation and Fracture (including Chip Fractures) are sustained as a result of the Accident, the maximum benefit payable for all Dislocations and Fractures is up to 200% of the highest applicable amount.

For an additional Dislocation of the same joint/joint group for a Covered Person as the result of a different Accident, the benefit amount payable is 25% of the applicable benefit amount shown in the Benefit Schedule. However, if a benefit was paid for a joint/joint group and a Covered Person subsequently sustains a Dislocation of that same joint/joint group for which a higher benefit is payable as the result of a different Accident, We will pay any difference in the two amounts as an additional benefit amount.

EYE INJURIES

Object Removal Benefit
We will pay the Object Removal Benefit Amount shown in the Benefit Schedule if a Covered Person injures an eye as the result of an Accident which requires the removal of an embedded foreign object from the eye.

The removal must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If both an object removal and surgical repair occurs for a Covered Person for the same eye as a result of the same Accident, only the highest applicable benefit is payable.

Surgical Repair Benefit
We will pay the Surgical Repair Benefit Amount shown in the Benefit Schedule if a Covered Person injures an eye as the result of an Accident which results in surgical repair of the eye.

The surgical repair must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If both a surgical repair and an object removal occurs for a Covered Person for the same eye as a result of the same Accident, only the highest applicable benefit is payable.

FRACTURES

Fractures Benefit
We will pay the applicable Fractures Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a Fracture or Chip Fracture as the result of an Accident. The benefit amount for a Fracture is based on the type of Treatment received for the Fracture.

The initial Treatment of the Covered Injury must occur by a Physician or Medical Professional within 30 days after the Accident. The diagnosis of the Fracture or Chip Fracture must occur by a Physician or Medical Professional within 365 days after the Accident and must be confirmed by X-Ray or a Diagnostic Exam. This benefit is only payable once per bone/bone group (as listed in the Benefit Schedule) per Accident for each Covered Person.

If a Fracture is Treated with both Closed Reduction and Open Reduction, or if the same bone/bone group sustains both a Fracture and a Chip Fracture, only the highest applicable benefit amount for that bone/bone group is payable. If a

Fracture or Chip Fracture is sustained for more than one bone/bone group as a result of the Accident, the maximum benefit payable is up to 200% of the highest applicable amount.

If both a Fracture (including a Chip Fracture) and Dislocation are sustained as a result of the Accident, the maximum benefit payable for all Fractures and Dislocations is up to 200% of the highest applicable amount.

LACERATIONS

Lacerations Benefit
We will pay the applicable Lacerations Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a Laceration as the result of an Accident. The benefit amount is based on whether the Laceration is repaired with a Laceration Repair Method and the length of the Laceration.

The initial Treatment of the Laceration must occur by a Physician or Medical Professional within 30 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If a Covered Person sustains more than one Laceration as a result of the Accident, only the highest applicable benefit amount is payable. The total length of all Lacerations sustained in the Accident by the Covered Person will determine the benefit amount.

If an Injury meets the definition of both a Laceration and a Puncture Wound, or if a Covered Person undergoes any form of Surgery in conjunction with a Laceration, only the highest applicable benefit is payable.

OTHER INJURIES

Ear Injury Benefit
We will pay the Ear Injury Benefit Amount shown in the Benefit Schedule if a Covered Person sustains damage to an ear as the result of an Accident which results in long-term severe hearing loss with a hearing loss range of 56 decibels (dB HL) or higher (unable to hear sound unaided at or below 55 dB HL).

Initial Treatment for the ear injury must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is only payable once per ear for each Covered Person under the Policy.

This benefit is not payable for loss of hearing due to Illness or if a Functional Loss benefit is payable for the same ear. If this benefit is paid and a Covered Person subsequently sustains further Covered Injury for which a higher Functional Loss benefit is payable, the amount of the Functional Loss benefit will be reduced by any Ear Injury Benefit paid for the same ear.

Gunshot Wound Benefit
We will pay the Gunshot Wound Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a gunshot wound from a Conventional Firearm as the result of an Accident.

The initial Treatment of the gunshot wound must occur by a Physician or Medical Professional within 24 hours after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable for any self-inflicted gunshot wound. A copy of the police report or report from an appropriate authority documenting the circumstances of the gunshot wound must be submitted with the claim.

Puncture Wound Benefit
We will pay the Puncture Wound Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a Puncture Wound as the result of an Accident.

The initial Treatment of the Puncture Wound must occur by a Physician or Medical Professional within 30 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable for any self-inflicted Puncture Wound. For a Puncture Wound that is a stab wound caused by the use of a knife or similar pointed object by another person to a Covered Person, a copy of the police report or report from an appropriate authority documenting the circumstances of the stab wound must be submitted with the claim.

If a Covered Injury meets the definition of both a Puncture Wound and a Laceration, or if a Covered Person undergoes any form of Surgery for the Puncture Wound, only the highest applicable benefit is payable.

SURGERY BENEFIT(S)

If a Covered Person undergoes more than one type of Surgery for the same Covered Injury, or if a Covered Injury qualifies for more than one Surgery Benefit, only the highest applicable Surgery Benefit is payable for that Covered Injury. If We pay a Surgery Benefit for a Covered Injury and a Covered Person subsequently undergoes an additional Surgery for that same Covered Injury for which a higher benefit is payable, We will pay any difference in benefit amounts.

If a Covered Person undergoes Surgery for more than one Covered Injury sustained as a result of an Accident, the maximum benefit payable for all Surgery Benefits is up to 200% of the highest applicable amount.

Undergoing a Laceration Repair Method to repair a Laceration is not payable under any Surgery Benefit.

Exploratory Surgery or Debridement Benefit
We will pay the Exploratory Surgery or Debridement Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Exploratory Surgery or a Debridement Procedure as the result of one or more Covered Injuries.

Initial Treatment of the Covered Injury(ies) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgical Procedure must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Minimally Invasive (Scope-Based) Surgery Benefit
We will pay the Minimally Invasive (Scope-Based) Surgery Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Minimally Invasive (Scope-Based) Surgery to repair one or more Covered Injuries.

Initial Treatment of the Covered Injury(ies) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Abdominal, Cranial or Thoracic Surgery Benefit
We will pay the Abdominal, Cranial or Thoracic Surgery Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes abdominal, cranial or thoracic Surgery to repair one or more Covered Injuries.

Initial Treatment of the Covered Injury(ies) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If a Covered Person undergoes cranial or thoracic Surgery and an Open Reduction of a Dislocation or Fracture for the same Covered Injury, only the highest applicable benefit is payable.

This benefit is not payable for the repair of a hernia.

Hernia Repair Benefit
We will pay the Hernia Repair Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Surgery to repair a hernia sustained as a result of an Accident.

The hernia must be diagnosed by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable for the repair of any hernia that is not caused directly by an Accident, whether or not the hernia was diagnosed prior to the Accident.

Herniated Disc Repair Benefit
We will pay the Herniated Disc Repair Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Surgery to repair one or more Herniated Discs sustained as a result of an Accident.

Initial Treatment of the Herniated Disc(s) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable for the repair of any Herniated Disc that is not caused directly by an Accident, whether or not the Herniated Disc was diagnosed prior to the Accident.

Joint Replacement Benefit
We will pay the Joint Replacement Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Surgery to replace an elbow, hip, knee or shoulder (glenohumeral) joint as the result of one or more Covered Injuries.

Initial Treatment of the Covered Injury(ies) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If a Covered Person undergoes Surgery to replace a joint and an Open Reduction of a Dislocation or Fracture for the same Covered Injury, only the highest applicable benefit is payable.

Knee Cartilage Repair Benefit
We will pay the Knee Cartilage Repair Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Surgery to repair torn, ruptured or severed knee cartilage (meniscus) sustained as the result of an Accident.

Initial Treatment of the knee Injury must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If a Covered Person undergoes Surgery to repair knee cartilage and an Open Reduction of a Dislocation or Fracture for the same Covered Injury, only the highest applicable benefit is payable.

Other Non-Specified Surgery Benefit
We will pay the Other Non-Specified Surgery Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes a Surgery that is not otherwise included/specified as a Surgery Benefit as the result of one or more Covered Injuries.

Initial Treatment of the Covered Injury(ies) must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If a Covered Person undergoes a non-specified Surgery and an Open Reduction of a Dislocation or Fracture for the same Covered Injury, only the highest applicable benefit is payable.

Tendon, Ligament or Rotator Cuff Repair Benefit
We will pay the applicable Tendon, Ligament or Rotator Cuff Repair Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes Surgery to repair damage to a ligament, tendon or rotator cuff sustained as the result of an Accident.

Initial Treatment of the ligament, tendon or rotator cuff Injury must occur by a Physician or Medical Professional within 30 days after the Accident. The Surgery must be performed by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

If more than one ligament, tendon or rotator cuff is repaired through the same surgical incision, it is considered one repair. If a Covered Person undergoes Surgery to repair a ligament, tendon or rotator cuff and an Open Reduction of a Dislocation or Fracture for the same Covered Injury, only the highest applicable benefit is payable.

Outpatient Surgery Facility Fee Benefit
We will pay the Outpatient Surgery Facility Fee Benefit Amount shown in the Benefit Schedule if a Covered Person undergoes a Surgery on an Outpatient basis as the result of one or more Covered Injuries for which a benefit is payable under the Policy.

This benefit is payable once per Accident for each Covered Person. This benefit is payable in addition to any other Surgery Benefits payable.

Blood Products Benefit
We will pay the Blood Products Benefit Amount shown in the Benefit Schedule if a Covered Person receives an administration of Blood Products as the result of one or more Covered Injuries.

The Blood Products must be prescribed by a Physician on an emergency basis or provided while the Covered Person is undergoing Surgery. This benefit is payable once per Accident for each Covered Person.

This benefit is payable in addition to any other Surgery Benefits payable.

General Anesthesia Benefit
We will pay the General Anesthesia Benefit Amount shown in the Benefit Schedule if a Covered Person receives General Anesthesia for a Surgery for which a benefit is payable under the Policy.

The anesthesia must be administered by a Certified Registered Nurse Anesthetist (CRNA) or appropriately licensed anesthesiologist. This benefit is payable once per Accident for each Covered Person.

This benefit is payable in addition to any other Surgery Benefits payable. This benefit is not payable for any other forms of anesthesia, such as topical anesthesia, local anesthesia, epidural or spinal anesthesia or peripheral nerve blocks.

CATASTROPHIC BENEFITS

DEATH

Basic Death Benefit
We will pay the applicable Basic Death Benefit Amount shown in the Benefit Schedule if a Covered Person dies as the result of one or more Covered Injuries sustained in an Accident.

The death must occur within 365 days after the Accident and be independent of all other causes.

This benefit is not payable if the Common Carrier Death Benefit is payable for a Covered Person as a result of the same Accident. The Basic Death Benefit Amount will be reduced by the amount of any other Catastrophic Benefits paid for a Covered Person as the result of the same Accident, unless otherwise indicated within any Catastrophic Benefits provision.

Common Carrier Death Benefit
We will pay the applicable Common Carrier Death Benefit Amount shown in the Benefit Schedule if a Covered Person dies as the result of one or more Covered Injuries sustained in an Accident while a fare-paying passenger on a Common Carrier.

The death must occur within 90 days after the Accident and be independent of all other causes.

This benefit is not payable if a Covered Person was an operator or member of the crew on the Common Carrier conveyance at the time of the Accident.

The Common Carrier Death Benefit Amount will be reduced by the amount of any other Catastrophic Benefits paid for a Covered Person as the result of the same Accident, unless otherwise indicated within any Catastrophic Benefits provision.

Transportation of Remains Benefit
We will pay the Transportation of Remains Benefit Amount shown in the Benefit Schedule for the preparation and transportation of a Covered Person's remains, if:

1) a Covered Person dies as the result of an Accident for which a death benefit is payable under the Policy; and
2) the death occurs more than 100 miles away from their primary residence.

The Covered Person's bodily remains or ashes must be transported to a mortuary or funeral home within 100 miles of their primary residence by an appropriately licensed company that provides mortuary transport services. This benefit is only payable once under the Policy for each Covered Person.

This benefit is not payable for the transportation expense of any person accompanying the remains.

Proof of the expense incurred for the preparation and transportation of the remains must be submitted with the claim. Mileage is measured as the distance from the Covered Person's primary residence to the location where the death occurred, and to the mortuary or funeral home.

This benefit is payable in addition to any other Catastrophic Benefits payable.

Exposure and Disappearance
If a Covered Person is unavoidably exposed to the elements of nature or one or more Chemical Elements as the direct result of an Accident and as a result of such exposure dies, the Covered Person will be presumed to have died, for the purpose of any death benefit, as the result of the Accident.

A Covered Person will be presumed to have died, for the purpose of any death benefit, if the Covered Person disappears and the disappearance:

1) is caused by or is the result of an Accident that could reasonably have caused death;
2) the Covered Person's body is not found within 1 year from the date of disappearance (unless otherwise required or allowed by applicable law) despite reasonable search efforts; and
3) a valid death certificate is issued by a court of appropriate jurisdiction.

DISMEMBERMENT/FUNCTIONAL LOSS

Dismemberment/Functional Loss Benefit
We will pay the applicable Dismemberment/Functional Loss Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries that result in a Dismemberment or Functional Loss. For any Catastrophic Dismemberment/Functional Loss Benefit to be payable, the Covered Injury(ies) that qualifies for the benefit must be sustained by the Covered Person as a result of the same Accident.

The Dismemberment must occur, or Functional Loss must be diagnosed by a Physician or Medical Professional, within 365 days after the Accident and be independent of all other causes. This benefit is only payable once per Accident for each Covered Person.

If a Covered Injury falls under more than one of the Dismemberment or Functional Loss classifications shown in the Benefit Schedule, or if more than one form of Dismemberment occurs for parts of the same limb, only the highest applicable benefit amount is payable. If We pay this benefit and subsequently an additional Dismemberment or Functional Loss is sustained by a Covered Person for the same body part for which a higher benefit is payable as a result of the Accident, We will pay any difference in the two amounts as an additional benefit amount.

If more than one Dismemberment, Functional Loss or Paralysis are sustained by a Covered Person as a result of the same Accident, the maximum benefit payable for the Accident is up to 150% of the highest applicable amount.

PARALYSIS

Paralysis Benefit
We will pay the applicable Paralysis Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries that result in Paralysis.

The Paralysis must be diagnosed by a Physician within 365 days after the Accident and be independent of all other causes. This benefit is only payable once per Accident for each Covered Person.

If more than one form of Paralysis occurs as a result of the same Accident, only the highest applicable benefit amount is payable. If We pay this benefit and subsequently an additional Paralysis is sustained by a Covered Person for which a higher benefit is payable as a result of the Accident, We will pay any difference in the two amounts as an additional benefit amount.

If more than one Dismemberment, Functional Loss or Paralysis is sustained by a Covered Person as a result of the same Accident, the maximum benefit payable for the Accident is up to 150% of the highest applicable amount.

OTHER CATASTROPHIC BENEFITS

Coma Benefit
We will pay the Coma Benefit Amount shown in the Benefit Schedule if a Covered Person is in a Coma for 7 or more consecutive days as the result of one or more Covered Injuries sustained in an Accident.

The Covered Person must become Comatose within 90 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is payable in addition to any other Catastrophic Benefits payable.

Prosthetic Device Benefit
We will pay the applicable Prosthetic Device Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries that result in the Dismemberment of an arm, hand, foot or leg or loss of an eye, following which a Prosthetic Device is received. The benefit amount payable is based on the number of devices received by the Covered Person.

The device must be prescribed by a Physician or Medical Professional for functional use and be received within 365 days after the Accident. This benefit is payable once per Accident for each Covered Person.

This benefit is not payable for more than one Prosthetic Device for the same body part, or for the replacement of a Prosthetic Device for which a benefit was previously paid for a Covered Person, under this Policy.

This benefit is payable in addition to any other Catastrophic Benefits payable.

Reasonable Modifications – Residence or Vehicle Benefit
We will pay the Reasonable Modifications – Residence or Vehicle Benefit Amount shown in the Benefit Schedule for the Reasonable Modifications of a Covered Person's primary residence and/or vehicle if a Covered Person sustains one or more Covered Injuries for which:

1) a Catastrophic Dismemberment/Functional Loss Benefit; or
2) a Paralysis Benefit for two or more limbs (excluding monoplegia or uniplegia);

is payable under the Policy.

A Physician must certify that any modification is needed to accommodate a physical disability of the Covered Person. The modification(s) must occur within 730 days after the Accident. This benefit is payable once per Accident for each Covered Person.

Any modification must be:

1) made by someone experienced in such modifications who is not the Covered Person or a Family Member; and
2) completed in compliance with any requirements established by the appropriate government authority or manufacturer (if applicable).

Proof of the expense incurred for any modification and the Physician's certification must be submitted with the claim.

This benefit is payable in addition to any other Catastrophic Benefits payable.

EXCLUSIONS

The exclusions included below apply to all benefits included in this Certificate unless otherwise noted below. Please note that certain benefits may have additional limitations or requirements presented in the benefit provisions and definitions of this Certificate.

Exclusions
No benefits are payable under the Policy for any Accident, Injury or loss that results from, is caused by or occurs during a Covered Person's:

1) voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities (except for misdemeanor violations), voluntary Participation in a Riot, or voluntary engagement in an illegal occupation;
2) incarceration or imprisonment following conviction for a crime;
3) travel in or descent from any vehicle or device for aviation or aerial navigation, except:
   a) as a fare-paying passenger in a commercial aircraft (other than a charter airline) that flies at a level no higher than the Earth's stratosphere on a regularly scheduled passenger flight; or
   b) while traveling on business of the Policyholder;
4) riding 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;
5) participation in any organized sport in a professional or semi-professional capacity for which the Covered Person receives remuneration or payment;
6) 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, luging, 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;
7) 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;

8) 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; or
9) use of illegal fireworks (as defined by the law of the jurisdiction in which the Injury or loss occurred) or the use of any legal fireworks when not following the manufacturer's lighting instructions.

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) medical mishap or negligence on the part of any acupuncturist, Chiropractor, Therapist, Physician or Medical Professional, including malpractice;
2) Treatment, supplies or services provided by, through or on behalf of any government agency or program, unless payment is required by a Covered Person; and
3) elective or cosmetic surgery or procedures classified by the treating Physician to be elective or cosmetic, except for reconstructive surgery incidental to or following surgery for trauma of the involved body part.

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.

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 date:
1) of an Accident;
2) of service or Treatment for any Covered Injury; or
3) an expense or service is incurred as the result of an Accident;

for which benefits are sought 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 within 30 days after Our receipt of due Proof of Loss.

Payment of Claims
All benefits are payable to You. Any benefits unpaid at the time of Your death, or benefits payable as a result of Your death, will be paid to Your designated beneficiary(ies), or if none, then in the following order to:
1) Your Spouse;
2) Your children;
3) Your parents;
4) Your siblings; or
5) 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. Spousal consent may not apply to ERISA plans. Please consult Your legal advisor for additional information. 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 no event may a Power of Attorney change a beneficiary designation, unless legally granted by You or Your assignee (if You absolutely assigned this insurance).

Claim Denial
If a claim for benefits is wholly or partly 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 their 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 an Accident or other loss; or
    b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of an Accident 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
This insurance is provided under a contract of group insurance with the Policyholder. The entire contract between the Policyholder and Us includes the following:

1) the Policy, which includes the Certificate(s) for each Eligible Class of the Policy;
2) the Policyholder's signed application (if any); and
3) any riders, amendments or endorsements to the Policy.

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, their 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 90 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 the true facts will be used to determine:

1) if, and for what amount, coverage should have been in force; and
2) if the Covered Person is eligible for any benefit that includes age-based requirements.

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 Your rights and interest under the Policy.

Insurance Fraud
Insurance fraud occurs when any person or the Policyholder provides 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 or the Policyholder commits 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 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.

Policy Interpretation
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. This provision applies where the interpretation of the Policy is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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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.

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1. **Plan Name**

   For employees of :

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2. **Plan Number**

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3. **Employer/Plan Sponsor**

   ,

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4. **Employer Identification Number**

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5. **Type of Plan**

   Welfare Benefit Plan providing:

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6. **Plan Administrator**

   ,

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7. **Agent for Service of Legal Process**

For the Plan

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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.

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8. **Sources of Contributions**

(Group Accident 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.

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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.

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

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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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 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.