YOUR BENEFIT PLAN



Hospital Cash Benefits

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Maryland

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

State Notices

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

The insurance carrier for the Policy is:	**The 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 from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

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

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

Alaska:

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

Arizona:

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

Arkansas:

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

California:

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

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, does not apply to You.
3. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833
   Web Address: www.insurance.ca.gov

Colorado:

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

   If a claim for benefits has been denied in whole or in part and all administrative remedies have been exhausted, the claimant is entitled to have the claim reviewed de novo (from the beginning) in any court with jurisdiction and to a trial by jury.
3. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to You.

Connecticut:

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

Florida:

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

Georgia:

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

Idaho:

1. The time period for **Treatment** described in the **Pre-Existing Condition** definition, if shown in the **Definitions** section, is six (6) consecutive months, unless if shown as less.
2. Childbirth and non-professional activity exclusions are not applicable to You, if shown in the **Exclusions** provision of the **Limitations and Exclusions** section of the Certificate.
3. Proof of a handicap or disability of a **Dependent Child**, if included in the **Definitions** section, will only be required at time of claim and no more than once per year thereafter.
4. You are entitled to receive benefits for up to 31 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.
5. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. 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
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable to You.
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

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

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

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance.

Indiana:

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

Kansas:

1. The following requirement applies to You:

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

review of Your eligibility or entitlement to benefits under the Policy. This provision only applies where the interpretation of the Policy is governed by ERISA.

Maine:

1. **NOTICE:** If You have a Medicare supplement policy or major medical policy, this coverage may be more than You need. For information, call the Bureau of Insurance at (800) 300-5000.
2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.
3. You are entitled to cover Your **Dependent Child**, if available under the Policy, up to age 19, unless if shown as higher in the **Definitions** section of the Certificate.
4. You are entitled to receive benefits for up to 31 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.

Michigan:

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

Minnesota:

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

Missouri:

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

Montana:

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

New Hampshire:

1. The **Pre-Existing Condition Limitation**, if shown in the **Limitations and Exclusions** section, is not applicable to You.
2. There is no defined time period from which You must submit Proof of Loss should You be unable to reasonably provide it within the first 90 days.
3. You are entitled to receive benefits for up to 61 days for any covered period of Hospital Confinement, unless if shown as higher in the **Benefits** section of the Certificate.
4. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
5. Termination of coverage has no effect on benefits payable for Treatment that is received for a Covered Illness or Covered Injury, as applicable, while a Covered Person was insured under the Policy.
6. The following **Extension of Coverage While Disabled** provision is added to the **Extension of Coverage** section of the Certificate:
   Extension of Coverage While Disabled
   If You are Disabled when coverage would otherwise terminate because:
   1) You are no longer eligible for insurance or are no longer in an Eligible Class; or

2) the Policy terminated;

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

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

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

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

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

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

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

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

New Mexico:

1. You are entitled to cover Your **Dependent Child**, if available under the Policy, up to age 26.
2. **NOTICE TO CONSUMER: This is a limited benefit health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-3935 (TTY: 711)**
3. Benefits paid on behalf of a Covered Person under this Certificate shall be paid to the human services department when:
   1) the human services department has paid or is paying benefits on behalf of the Covered Person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
   2) payment for the services in question has been made by the human services department to the Medicaid provider; and
   3) We are notified that the Covered Person receives benefits under the Medicaid program.
4. If You are covered under a Non-ERISA policy issued outside of New Mexico with a certificate effective date of January 1, 2019 or later, these additional requirements apply to you:
   A. Benefits payable under this Certificate will be paid immediately after Our receipt of due written **Proof of Loss**. If a claim is paid more than 45 days from receipt of required **Proof of Loss**, You are entitled to interest on that amount at the rate of 1 1/2 times the prime lending rate, as determined by the superintendent, for New Mexico banks per year during the period the claim is unpaid.
   B. **Legal Actions** may not start until 60 days after Proof of Loss has been given or more than 3 years after the time proof of loss is required to be given, unless otherwise required by law in Your or the claimant's jurisdiction of residence.
   C. **Physician** means a person who is:
      a. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art recognized by New Mexico law;
      b. licensed to practice in the jurisdiction where care is being given;

c. operating within the scope of his or her license; and
d. not the Covered Person or a Family Member.

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

D. If an unmarried child is age 26 or older and is:
   a. incapable of self-sustaining employment because of an intellectual disability or physical handicap;
   b. chiefly dependent on You for financial support;

   and You have provided proof of his/her disability upon Our request, that child will continue to be a **Dependent Child** until these conditions cease to exist. We may request that proof of such incapacity and dependency is furnished to us within 31 days of the child's attainment age 26 and subsequently as may be required by us, but not more frequently than annually after the two year period following the child's attainment age of 26.

E. **Newborn and Newly Adopted Child Coverage:**
   If, while covered under the Policy, You:
   a. have a newborn child;
   b. adopt a child;
   c. receive a stepchild; or
   d. become the legal guardian of a child;

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

   Coverage of the new child will cease after 31 days from the date the child became eligible unless You:
   a. enroll the new child prior to the expiration of the 31 days; and
   b. pay the additional required premium.

F. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for **Dependent** coverage.

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

North Carolina:

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

North Dakota:

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

Oregon:

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

Rhode Island:

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

South Dakota:

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

Texas:

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

Have a complaint or need help?

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

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

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford
Email: GBD.Customerservice@hartfordlife.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

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

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

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

Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: GBD.Customerservice@hartfordlife.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

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

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

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

Virginia:

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

Wisconsin:

1. **For Your Questions and Complaints:**
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (within Wisconsin)
   1(608) 266-0103 (outside of Wisconsin)

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GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)



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

Policyholder: MAGNA INTERNATIONAL OF AMERICA, INC.
Policy Number: VHI-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. This Certificate replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy on file with Us at Our Home Office. The Policy may be inspected at the office of the Policyholder.

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

Kevin Barnett, *Secretary*

Michael J. Fish, *President*

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

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

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

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

A note on capitalization in this Certificate:
Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in the Policy or refers to a specific provision contained herein.

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BENEFIT SCHEDULE

Eligible Class(es)
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 for Illness and Injury/Accident

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

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

Other Hospital Indemnity Policy Limitation (Over-insurance Limitation)
Included

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

BENEFIT(S) TABLE

Benefit:	**Hospital Indemnity Benefit Amount:**
Hospital Care Benefit(s)	
First Day Hospital Confinement	$1,000 per day
Daily Hospital Confinement (day 2 forward)	$200 per day
Daily ICU Confinement (day 2 forward)	$500 per day

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Change in Family Status means one of the following events:

1) You get married;
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 hospital indemnity insurance sponsored by the Spouse's employer for You or any Dependent(s); or
7) You change work classification from part-time to full-time or from full-time to part-time.

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

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

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

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

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

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

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

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

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

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

who is/are under 26 years of age.

If an unmarried child is age 26 or older and is:
1) incapable of self-sustaining employment because of a mental or physical disability;
2) chiefly dependent on the Employee or Spouse for financial support and maintenance;

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

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

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

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:
1) be staffed and equipped to handle trauma;
2) be under the direct supervision of a Physician;
3) provide Treatment by Physicians and/or Medical Professionals; and
4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

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

This definition does not include a person working for the Policyholder:
1) on a temporary, leased or seasonal basis;
2) as an independent contractor (including persons for whom income is reported on a 1099 form);
3) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
4) who resides outside the United States for a period in excess of 12 months, unless written approval has been received from Us.

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

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

Hospital means an institution:

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

Hospital does not include:

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

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

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

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

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

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

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

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

This definition does not include a private monitored room.

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

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

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

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

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

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

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

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

Physician means a person who is:

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY AND EFFECTIVE DATES

Eligibility for Coverage
An Employee will become eligible for coverage under the Policy on the latest of:
1) the Policy Effective Date;
2) the date he/she becomes a member of an Eligible Class; or
3) the date he/she completes the Eligibility Waiting Period.

A Dependent will become eligible for coverage under the Policy on the later of:
1) the date the Employee becomes insured under the Policy; or
2) the date You acquire the Dependent.

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

If more than one person within an immediate family unit is eligible for coverage under the Policy as an Employee of the Policyholder, then:
1) neither Employee may be covered as a Dependent of the other person; and
2) Dependent Child(ren) may only be covered as a Dependent of one Employee.

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

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

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

Coverage Effective Date
Coverage will start on the latest to occur of:
1) the first day of the month following the date an Employee or Dependent becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
2) the Policy Anniversary on or next following the last day of an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or
4) the first day of the month following the date an Employee or Dependent is enrolled.

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

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

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

All Coverage Effective Dates, Changes in Coverage effective dates, New Dependent Coverage effective dates and Reinstatement of Coverage effective dates for a Dependent will also be deferred if on the date the Dependent is to become covered, he or she is Confined or Confined Elsewhere. Such coverage will not start until the day after the Dependent:
1) is no longer Confined or Confined Elsewhere; and

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

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

This provision does not apply to:
1) any newborn Dependent Child, regardless of Confinement; or
2) any disabled child who qualifies under the definition of Dependent Child(ren).

Changes in Coverage
An Employee may elect, drop, increase, decrease or otherwise change coverage only:
1) during an Annual Enrollment Period or any Additional Enrollment Event; or
2) within 31 days of a Change in Family Status.

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

subject to the Deferred Effective Date provision.

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

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

New Dependent Coverage
If You:
1) marry; or
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 for You and any Dependent Child(ren):
1) under a Continuation provision; or
2) under the Extended Continuation provision.

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

REINSTATEMENT OF COVERAGE

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

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

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

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

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

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

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

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

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

Continuation Option(s)
Leave of Absence: If You are on a leave of absence approved by the Policyholder due to any personal reason, coverage may be continued for up to 1 month(s) from the date You ceased Active Work.

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

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

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 month(s) 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 month(s) 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 him/herself 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

HOSPITAL CARE BENEFITS

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

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

This benefit is not payable:
1) for Treatment in an Emergency Room, as an Outpatient, in an Observation Unit or other observation area of a Hospital, or for a Hospital stay of less than 20 hours; or
2) if a Covered Person is discharged from the Hospital and again becomes an Inpatient for the same or related Covered Illness or Covered Injury.

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

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

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

This benefit is not payable for:
1) any day for which a First Day Hospital Confinement benefit is payable; or
2) Treatment in an Emergency Room, as an Outpatient, in an Observation Unit or other observation area of a Hospital, or for a Hospital stay of less than 20 hours.

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

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

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

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

LIMITATIONS AND EXCLUSIONS

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

We will return the amount of premium paid for any Other Hospital Indemnity Policy that is declined by You retroactive to the later of:
1) the last date any benefit was paid for any Covered Person under the Other Hospital Indemnity Policy; or
2) the effective date of insurance for You under the Other Hospital Indemnity Policy.

Exclusions
No benefits are payable under the Policy for any Illness or Injury that results from or is caused by a Covered Person's:
1) suicide or attempted suicide, whether sane or insane, or intentional self-infliction;
2) voluntary intoxication (as defined by the law of the jurisdiction in which the Illness or Injury occurred) or while under the influence of any narcotic, drug or controlled substance, unless administered by or taken according to the instruction of a Physician or Medical Professional;
3) voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;

4) 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;
5) incarceration or imprisonment following conviction for a crime;
6) travel in or descent from any vehicle or device for aviation or aerial navigation, except as a fare-paying passenger in a commercial aircraft (other than a charter airline) on a regularly scheduled passenger flight or while traveling on business of the Policyholder;
7) ride in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing;
8) participation in any organized sport in a professional or semi-professional capacity;
9) 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;
10) travel or activity outside the United States or Canada;
11) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate; or
12) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer.

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

In addition, We will not pay for any benefits under the Policy, unless required by law for:
1) elective abortion or complications thereof;
2) artificial insemination, in vitro fertilization, test tube fertilization;
3) sterilization, tubal ligation or vasectomy, and reversal thereof;
4) aroma therapeutic, herbal therapeutic, or homeopathic services;
5) any Mental and Nervous Disorder, unless specifically allowed by a provision of this Certificate;
6) Substance Abuse, unless specifically allowed by a provision of this Certificate;
7) medical mishap or negligence on the part of any Physician, Medical Professional, or Therapist, including malpractice;
8) Treatment, supplies or services provided by, through or, on behalf of any government agency or program, unless payment is required by a Covered person;
9) Custodial Care, unless specifically allowed by a benefit provision in this Certificate or any rider attached to the Policy (if applicable);
10) elective or cosmetic surgery or procedures, except for reconstructive surgery:
    a) incidental to or following surgery for disease, infection or trauma of the involved body part; or
    b) due to Congenital Anomaly or disease of a Dependent Child which has resulted in a functional defect;
11) dental care or Treatment, except for:
    a) Treatment due to an Injury to sound natural teeth within 12 months of the Accident; and
    b) Treatment necessary due to congenital disease or anomaly.

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

CLAIM PROVISIONS

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

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

Claim Forms

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

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

Physical Examinations and Autopsy
We, at our own expense, shall have the right and opportunity to have:
1) a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims
Benefits payable under the Policy will be paid 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 will be paid to:
1) Your designated beneficiary(ies); or if none, then to
2) Your estate.

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

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

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

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

Claim Denial
If a claim for benefits is 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 his or her representative may appeal to Us for a full and fair review. To do so, the claimant:
1) must submit a written request for review within:
    a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of a Covered Illness or Covered Injury; or
    b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of a Covered Illness or Covered Injury or other loss; and

2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

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

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

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

If reimbursement is not made in a timely manner, We have the right to:
1) recover such overpayments from:
   a) You;
   b) any other person to or for whom payment was made; or
   c) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made;
3) refer the unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

GENERAL PROVISIONS

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

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

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

Legal Actions
No legal action may start:
1) until 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:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Assignment
You have the right to absolutely assign Your rights and interest under the Policy including, but not limited to, the following:
1) the right to make any contributions required to keep the insurance in force; and
2) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under the Policy, provided:
1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:
1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign his/her rights and interest under the Policy.

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

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

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

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

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

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.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.



Hartford Life and Accident Insurance Company ("The Hartford" or "we") is committed to protecting the privacy of your health information. The Hartford is required by a federal law - the Health Insurance Portability and Accountability Act (HIPAA) - to take reasonable steps to ensure the privacy of your "Protected Health Information" (PHI) and to provide you with this Notice of Privacy Practices. PHI includes all individually identifiable health information transmitted or maintained by The Hartford and/or its business associates regardless of form (oral, written, electronic).

This Notice applies to PHI obtained through the following coverages only: Hospital Indemnity, Critical Illness/Specified Disease, Retiree Medical (SMIP, GRIP, GRIP II) and (Standardized) Medicare Supplement, Prescription Drug coverage, Association Medicare Supplement, Medical Conversion Run-off, TRICARE and CHAMPVA Supplements and Long-Term Care.

Effective Date: This Notice was originally effective April 14, 2003 and as revised is effective March 10, 2022.

Uses and Disclosures of Your PHI

This section of the Notice explains how The Hartford uses and discloses your PHI with our employees, business associates, and other organizations as required or permitted by law without your authorization. We also require our business associates to protect the privacy of your PHI through written agreements with The Hartford. As explained below, we will request your written authorization in some instances to use or disclose PHI. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI as described herein, we will restrict our uses and disclosures of PHI in accordance with this more restrictive law.

Required Disclosures. The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate and/or determine The Hartford's compliance with HIPAA's privacy regulations.

Uses and Disclosures Related to Treatment, Payment and Healthcare Operations. The Hartford and/or its business associates may use and disclose PHI without your authorization or opportunity to agree or object for activities related to treatment, payment, and healthcare operations. In these instances, The Hartford will not request your authorization to share PHI. As described in the next section titled **Your Privacy Rights**, you have the right to request a restriction on the use and disclosure of your PHI for treatment, payment, or healthcare operations purposes. The Hartford may not use any PHI that is "genetic information" (as defined by the Genetic Information Nondiscrimination Act of 2008) for underwriting purposes. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities.

Examples of activities related to treatment include: treatment provided by a specialist who asks a primary care physician to share a patient's PHI.

Examples of activities related to payment include: payment of healthcare claims, determinations whether a member is eligible for healthcare coverage, or collection of premiums.

Examples of activities related to healthcare operations include: quality improvement; fraud and abuse prevention and detection; case management and medical review; underwriting; and complaint resolution.

Uses and Disclosures of Your PHI That Do Not Require Your Authorization or Opportunity to Object. Your PHI may be disclosed without your authorization in the following circumstances: when required by law; public health activities; instances involving victims of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, as required or permitted by law; governmental health oversight activities (including audits, investigations, and inspections); judicial and administrative proceedings; certain law enforcement purposes; deceased persons to coroners, health examiners, and funeral directors; organ and tissue donation; certain government-approved research purposes; upon reasonable belief to avert a serious threat to health or safety; specialized government functions (such as military personnel, and inmates in correctional facilities); to individuals involved in your care or payment for your care; emergency treatment situations; disaster relief; or workers' compensation.

Use and Disclosures to Plan Sponsor. In some circumstances, The Hartford may also disclose PHI to the sponsor of your group health plan for plan administration functions.

Use and Disclosure to Contact You Regarding Health-Related Benefits and Services. The Hartford or its business associates may also contact you regarding health-related benefits and services that may be of interest to you.

Uses and Disclosures That Require Your Written Authorization. In all other circumstances not described above, uses and disclosures of your PHI will only be made with your written authorization. For example, we will need your authorization for the following circumstances:

- most uses or disclosures of psychotherapy notes;
- marketing communications; and
- disclosures that constitute a sale of PHI.

You may revoke such an authorization at any time, except to the extent The Hartford, its business associates, or other entities have relied on such disclosure.

Your Privacy Rights

This section of the Notice describes your rights as an individual with respect to your PHI and a brief description of how you may exercise these rights.

Right to Restrict Uses and Disclosures for Treatment, Payment and Healthcare Operations Purposes. You have the right to request that we restrict uses and disclosure of your PHI for activities related to treatment, payment and healthcare operations as described above. Your request for the restriction must be in writing. We will evaluate all requests for restrictions, however, we are generally not required to agree to the restriction. In certain circumstances, we may be obligated to honor your request for a restriction on disclosures to another health plan relating to a health care item or service for which you paid in full. If we agree to the restriction, we will abide by it, except in the case of emergency treatment or when required by law. We will terminate our agreement to a restriction if you agree to or request the termination of the restriction. If we decide to terminate our agreement to the restriction, we will notify you of our decision.

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

If you have paid for a health care item or service out-of-pocket and in full, you may request that we do not disclose to a health plan any PHI related solely to the item or service. We are obligated to honor that request unless we are required by law to make a disclosure.

Right to Request Confidential Communications. You may request that we communicate with you by alternative means or at alternative locations. For example, you may wish to receive communications from us at your work location rather than your home. We will evaluate all such requests, however, we must only accommodate your request if you clearly state that the communication of all or part of your PHI could endanger you.

Right to Inspect and Copy Your PHI. You have a right to access, inspect, and copy your PHI contained in a "designated record set" for as long as The Hartford maintains the PHI in the designated record set. Your right to access your PHI contained in a designated record set extends to any such information that is maintained in an electronic health record or another electronic form. However, you do not have an automatic right to access psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a criminal, civil or administrative action or proceeding. We will act on a request for access within 30 days of receiving your request if the information is maintained and accessible on site or within 60 days otherwise (with a possible 30-day extension). We will provide you with a summary of the PHI requested if you agree in advance to the summary and to the fees imposed.

We may deny your request to access your PHI under certain circumstances. If your request is denied, we will send you a notice that explains our reason for the denial, your review rights (if any), and how to file a complaint with our Privacy Officer or the Secretary of the Department of Health and Human Services. In certain instances we will provide you with an opportunity for a review of the denial. The review decision must be made in a reasonable period of time, and we will send you a written notice of the review decision. We may charge a reasonable fee for access, inspection and/or copying of your PHI. This fee is based on the costs associated with copying, mailing, and summary preparation costs.

Right to Amend Your PHI. You have the right to request that we amend your PHI if you believe the information is incorrect or inaccurate. We may deny your request to amend your PHI if we did not create the PHI, if the information is not part of our records, if the information was not available for inspection, or if the information is accurate and complete. We will respond to your written request to amend your PHI within 60 days of the request (with a possible 30-day extension).

If your request for amendment is granted, we will notify you that the amendment was approved. Upon your identification of relevant persons, we will obtain your agreement to inform them of the change. We will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you and by us, including our business associates.

If your request for the amendment is denied, we will send you a written notice that explains the reason for the denial, your right to submit a written statement of disagreement or to have the request for amendment included with future disclosures, and your right to file a complaint with our Privacy Officer and/or the Secretary of the Department of Health and Human Services.

We may prepare a rebuttal statement to your statement of disagreement. We will provide you with a copy of the rebuttal statement.

Any future disclosures of your PHI will include the statement of disagreement or request for amendment, the denial notice, and the rebuttal or summary of this information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of disclosures of your PHI made by The Hartford during the six years prior to the date of your request. We will act on your request for an accounting of disclosures within 60 days (with a possible 30-day extension).

This accounting of disclosures will not include disclosures made: prior to effective date of HIPAA, April 14, 2003; for treatment, payment, and healthcare operations; to you or your personal representative; pursuant to an authorization; for national security or intelligence purposes, as provided in regulations under HIPAA; to correctional institutions or law enforcement officials, as provided in regulations under HIPAA; incident to a use or disclosure permitted or required by law; and to persons involved in your care (if you were present), you were incapacitated, or for disaster relief purposes.

We will provide you with one free accounting each year. For subsequent requests, we will charge a reasonable fee. The written accounting of disclosures will include the following information for each disclosure: the date of the disclosure, the person to whom the information was disclosed, a brief description of the information disclosed or in lieu of the summary, a copy of the written request for the disclosure.

Right to be Notified Following a Breach. You have a right to notified if there has been a breach involving your unsecured PHI.

***Right to a Copy of Notice of Privacy Practices*.** You have the right to receive a paper copy of this Notice upon request, even if you agreed to receive the Notice electronically.

***Complaints*.** You may file a complaint with The Hartford or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with The Hartford, contact the Consumer Rights and Privacy Compliance Unit at ConsumerPrivacyInquiriesMailbox@thehartford.com. We will not retaliate against you for filing a complaint.

Contact Information. If you have any questions about this Notice, or the subjects addressed in it including how to exercise your rights as set forth in this Notice, please contact the Consumer Rights and Privacy Compliance Unit at the email address above or call us at: 860-547-5000.

The Hartford's Duties

The Hartford will abide by the terms of this Notice of Privacy Practices.

The Hartford reserves the right to change its privacy practices and apply the changes to any PHI received or maintained by The Hartford prior to that date. If a privacy practice is materially changed, The Hartford will provide you with a revised Notice of Privacy Practices by mail or any other reasonable method of communication used to process or service your insurance or transactions with us.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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

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

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

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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 Hospital Indemnity Insurance) The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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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.