YOUR BENEFIT PLAN

SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST

Critical Illness

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State Notices

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

The insurance carrier for the Policy is:	**The Claims Administrator for the Policy is:**
The Hartford **Group Benefits Division,** **Customer Service** **P.O. Box 2999** **Hartford, CT 06104-2999** **1-800-523-2233**	**WebTPA** **P.O. Box 99906** **Grapevine, TX 76099** **1-866-547-4205**

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

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

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

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

NOTICES

- Arizona: If You are covered under a Policy issued to a trust group situsued outside of Arizona, the Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.
- Arkansas: You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
  Arkansas Insurance Department
  1 Commerce Way, Suite 102
  Little Rock, AR 72202
- California: **For Your Questions and Complaints:**
  State of California Insurance Department
  Consumer Services Division
  300 South Spring Street, South Tower
  Los Angeles, CA 90013
  Toll Free: 1(800) 927-HELP
  TDD Number: 1(800) 482-4833
  Web Address: www.insurance.ca.gov
- Connecticut: This is a specified disease 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.
- Florida: **The benefits under the Policy providing Your coverage are governed primarily by the laws of a state other than Florida, unless the issue state is Florida. Please contact the Policyholder with any questions.**

- Illinois: **The Religious Freedom Protection and Civil Union Act, Effective June 1, 2011**
  The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

  For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance.
- Illinois: **For Your Questions and Complaints:**
  Illinois Department of Insurance
  320 West Washington Street
  Consumer Services Station
  Springfield, Illinois 62767
  Consumer Assistance: 1(866) 445-5364
  Officer of Consumer Health Insurance: 1(877) 527-9431
  Web Address: http://insurance.illinois.gov/
- Pennsylvania: Hartford Life and Accident Insurance Company complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex including sex stereotypes and gender identity. Hartford Life and Accident Insurance Company 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.
- Texas: In addition to the insurance coverage, We may offer Noninsurance Benefits and Services to You. Your access to these benefits and services is included with Your insurance coverage and does not require enrollment or premium payment. You should contact the Policyholder for more information on the services available on their plan.

  Will Preparation Services: These services provide access to an online tool to create a customized will with the help of licensed attorneys, if needed.

  Travel Assistance Related Services: These services include emergency medical assistance such as medical referrals, monitoring, evacuation, repatriation and medical translation services.

  Identity Theft Related Services: These services include fraud prevention, credit monitoring, as well as resolution guidance and support to assist with problems that may arise from medical identity theft.

  Funeral Planning Services: These services provide support to You or Your beneficiaries to prepare for a funeral with access to online planning and research tools and advisors to answer questions.

  Employee Assistance Programs: Support is provided for a wide range of social and emotional issues. The program provides for either telephonic or face-to-face counseling sessions.

  Beneficiary Support Services: These services provide emotional, legal or financial guidance, answer benefit-related questions or provide referrals to You or Your beneficiaries.
- Texas:

  Have a complaint or need help?

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

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

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

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

Teléfono gratuito: 1-800-523-2233

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

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

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

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

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

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

CERTIFICATE FACE PAGE

- California: **This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.**
- Maine: **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.**
- Maryland: **The group insurance Policy providing coverage under the Certificate may have been issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.**

  THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT IS NOT DESIGNED TO FILL THE 'GAPS' OF MEDICARE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY.
- Massachusetts:

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

  MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

  This is a Limited Policy - Read it Carefully
- North Carolina: NO RECOVERY FOR PRE-EXISTING CONDITIONS – READ CAREFULLY. No benefits will be provided during the Pre-Existing Condition Limitation period of the Policy for a **Pre-Existing Condition**, if defined in the Definitions section of the Certificate.
- Texas: **THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

DEFINITIONS

- South Dakota: The hourly time requirement, described in the **Confined, Confinement** definition, does not apply to Your coverage.
- Minnesota, New Hampshire: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 26, provided Dependent Coverage is available under the Policy.

- Montana: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 25 unless shown as higher, provided Dependent Coverage is available under the Policy.
- New Hampshire: The unmarried Dependent Child requirement, described in the Dependent Child(ren) definition, does not apply, provided Dependent Coverage is available under the Policy.
- South Dakota: The definitions of **Medical Professional**, **Physician**, and **Therapist** include Family Members if they are the only qualified provider of such service in the area and acting within the scope of their practice.
- Maine, New Hampshire, South Dakota: The Treatment received period prior to the effective date of coverage or the effective date of an increase in coverage, described in the **Pre-Existing Condition** definition, if included, cannot be more than six (6) months.

TERMINATION OF COVERAGE

- North Carolina: **Important Cancellation Information – Please Read the provision entitled Termination of Coverage**

REINSTATEMENT OF COVERAGE

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

CONTINUATION AND EXTENSION OF COVERAGE

- New Hampshire: The following **Extension of Coverage While Disabled** provision is added to the **Continuation and Extension of Coverage** section:
  Extension of Coverage While Disabled
  If You are Disabled when coverage would otherwise terminate because You are no longer eligible for insurance or are no longer in an Eligible Class, or the Policy terminates, 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.

GENERAL LIMITATIONS & EXCLUSIONS

- Colorado, New Hampshire: The continuously insured exclusion period, described in the **Pre-Existing Condition Limitation** provision, if included, is 6 consecutive months.
- Minnesota: Intentional self-inflicted illness or Injury, if included in the **Exclusions** provision, does not apply to Your coverage.
- New Hampshire: The voluntary taking or using of any drug, narcotic, medication or sedative, the voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities, voluntary engagement in an illegal occupation, or incarceration or imprisonment in any type of penal or detention facility, if included in the **Exclusions** provision, does not apply to Your coverage.
- South Dakota: The voluntary taking or using of any drug, narcotic, medication or sedative, if included in the **Exclusions** provision, does not apply to Your coverage.

CLAIM PROVISIONS

- Maine: The initial notice of claim time frame, described in the **Notice of Claim** provision, is 30 days.
- New Hampshire: The initial proof of loss time frame, described in the **Proof of Loss** provision, is 90 days.
- North Carolina: The initial proof of loss time frame, described in the **Proof of Loss** provision, is 180 days.
- Minnesota: The payment time frame, described in the **Time of Payment of Claims** provision, is immediately upon Our receipt of due Proof of Loss.
- Minnesota: The **Payment of Claims** provision is amended to make any benefits unpaid at the time of Your death payable to Your designated beneficiary(ies); or if none, then to Your estate.
- Colorado: The **Claim Appeal** provision includes 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.

GENERAL PROVISIONS

- Alaska: The **Statements** provision is not applicable to statements made with the intent to defraud.

- Minnesota, New Hampshire, North Carolina: The **Time Limit on Certain Defenses** provision is not applicable to statements made with the intent to defraud.
- New Hampshire: The following sentence is added to the last paragraph of the **Assignment** provision:
  In no circumstance may You assign any benefit to a health care provider.
- Alaska, California, Colorado, Illinois, Kansas (Non ERISA groups), Michigan, Rhode Island, Texas, Vermont: The **Policy Interpretation** provision, if shown, is not applicable to Your coverage.
- Wyoming (groups subject to ERISA): The **Policy Interpretation** provision, if shown, includes the following notice:
  This benefit plan contains a discretionary clause. Determinations made by Hartford Life and Accident Insurance Company pursuant to the discretionary clause do not prohibit or prevent a claimant from seeking judicial review in court of Hartford Life and Accident Insurance Company decisions. By including this discretionary clause Hartford Life and Accident Insurance Company agrees to allow a court to review its determinations anew when a claimant seeks judicial review of Hartford Life and Accident Insurance Company determinations of eligibility of benefits, the payment of benefits or interpretations of the terms and conditions applicable to the benefit plan.

GROUP CRITICAL ILLNESS (SPECIFIED DISEASE) 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: SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST

Participating Employer: A PARTICIPATING EMPLOYER WHO IS A MEMBER OF SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST

Policy Number: VCI-750012

Account Number: VCI-750012

Policy Effective Date: January 1, 2024

Participating Employer Effective Date: January 1, 2024

Policy Anniversary: January 1

Participating Employer Anniversary: January 1

We have issued the Policy to the Policyholder to extend coverage to eligible Employees of each Participating Employer. The Policy is delivered in and governed by the laws of the state of South Carolina, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy that are important to the Covered Person(s) are summarized in this Certificate, consisting of this form and any additional forms which have been made a part of this Certificate. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy on file with Us at Our Home Office. The current version of the Certificate for each Eligible Class included in the Policy replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. The Policy may be inspected at the office of the Policyholder.

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

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

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

Notice to Buyer: This is a specified disease 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 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, they should review the Guide to Health Insurance for People with Medicare ("Medicare & You" handbook) available through www.medicare.gov/publications or from Us.

READ THIS CERTIFICATE CAREFULLY. The Primary Insured has a 30-day right from their Coverage Effective Date to examine this Certificate. If the Primary Insured is not satisfied, it may be returned to Us within 30 days from receipt of

this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.

A note on capitalization in this Certificate:

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

TABLE OF CONTENTS

Section:

BENEFIT SCHEDULE

Eligible Class(es)
All Full-time Active Employees

Eligibility Waiting Period
Please see Your certificate rider

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

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

Coverage Amount(s)
- **Employee**: Choice of $10,000; $20,000 or $30,000
- **Spouse**: 100% of the Employee's elected Coverage Amount
- **Dependent Child(ren)**: 50% of the Employee's elected Coverage Amount (per child)

Any amount of insurance for a Spouse or Dependent Child(ren) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. All Coverage Amount(s) are Guaranteed Issue.

Reoccurrence Benefit Separation Period
180 days

Policy Benefit Maximum
500%

The Policy Benefit Maximum is a percentage of the applicable Coverage Amount in effect for a Covered Person at the time of Diagnosis of a Critical Illness.

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

CRITICAL ILLNESS BENEFITS TABLE

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

All **Initial Occurrence Benefit Amounts** are a percentage of the applicable Coverage Amount in effect for a Covered Person at the time of Diagnosis of a Critical Illness, unless otherwise stated as a specific dollar amount.

All **Reoccurrence Benefit Amounts** are a percentage of the Initial Occurrence Benefit Amount for the applicable Critical Illness that is payable or was previously paid under the Policy for a Covered Person.

Critical Illness:	**Initial Occurrence Benefit Amount:**	**Reoccurrence Benefit Amount:**
CANCER & BENIGN TUMOR CATEGORY		
Cancer (Invasive)	100%	100%
Carcinoma in Situ (Non-Invasive)	25%	100%
Skin Cancer	$250	None
Bone Marrow Failure	25%	None
Benign Brain or Spinal Cord (Intradural) Tumor • Advanced Diagnosis	100%	None

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
HEART & VASCULAR CATEGORY		
Heart Attack (Myocardial Infarction)		
• ST-Segment Elevation Myocardial Infarction (STEMI)	100%	100%
• Non-ST Segment Elevation Myocardial Infarction (NSTEMI)	25%	100%
Coronary Artery Disease		
• Minor Diagnosis	10%	100%
• Major Diagnosis	100%	100%
Stroke		
• Mild Stroke	10%	100%
• Moderate Stroke	25%	100%
• Severe Stroke	100%	100%
Aneurysm		
• Abdominal Aortic Aneurysm or Thoracic Aortic Aneurysm - Major Diagnosis	100%	100%

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
MAJOR ORGAN CATEGORY		
Major Organ Failure	100%	100%
End Stage Renal Disease (ESRD)	100%	None
Acute Respiratory Distress Syndrome (ARDS)	25%	None

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
NEUROLOGICAL CONDITIONS CATEGORY		
Dementia		
• Advanced Diagnosis	100%	None
Parkinson's Disease		
• Advanced Diagnosis	100%	None
Amyotrophic Lateral Sclerosis (ALS)		
• Advanced Diagnosis	100%	None
Multiple Sclerosis (MS)		
• Advanced Diagnosis	100%	None

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
INFECTIOUS CONDITIONS CATEGORY		
Severe Infectious Disease		
• Major Diagnosis	25%	None

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
FUNCTIONAL LOSS & CATASTROPHIC CONDITIONS CATEGORY		
Coma	100%	100%
Loss of Hearing	100%	None
Loss of Sight	100%	None
Loss of Speech	100%	None
Permanent Paralysis	100%	None

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
CHILD CONDITIONS CATEGORY		
Cerebral Palsy		
• Early Diagnosis	10%	None
• Advanced Diagnosis	100%	None
Congenital Heart Defect	100%	None
Congenital Metabolic Disorder	100%	None
Genetic Disorder	100%	None
Structural Congenital Defect	100%	None

Critical Illnesses included in the Child Conditions Category must be Diagnosed during Childhood.

ADDITIONAL BENEFIT(S) TABLE

All Additional Benefits are subject to the applicable Definitions, Exclusions and other provisions of the Policy. The amounts and maximums shown below may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the Additional Benefit(s) and General Limitations & Exclusions sections of this Certificate.

Benefit:	Benefit Amount:	Benefit Maximum:
Health Screening	$100	Once per Policy Year

DEFINITIONS

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

Abdominal Aortic Aneurysm means an Aneurysm located in the abdominal (lower) part of the aorta that is:

1) 5 centimeters or larger in size;
2) less than 5 centimeters and is rapidly expanding; or
3) a Dissecting Aneurysm or a Ruptured Aneurysm.

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

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

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

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

Activities of Daily Living (ADLs) means the following 6 basic daily activities or self-care tasks:

1) bathing, including washing oneself:
   a) in a tub or shower, including the task of getting into or out of the tub or shower; or
   b) by sponge bath;
2) continence, including:
   a) maintaining control of bowel and bladder function; or
   b) when unable to maintain control of such functions, the ability to perform associated personal hygiene tasks (including caring for a catheter or colostomy bag);
3) dressing, including putting on and taking off:
   a) all items of clothing; and
   b) any necessary braces, fasteners or artificial limbs;
4) eating, including feeding oneself by:
   a) getting food into the body from a receptacle (such as a bowl, cup or plate); or
   b) a feeding tube or intravenously;
5) toileting, including:
   a) getting to and from the toilet;
   b) on and off the toilet; and
   c) the ability to perform associated personal hygiene tasks; and
6) transferring, including the ability to:
   a) move into or out of a bed, chair or wheelchair; or
   b) move from place to place, either via walking or with an assistive mobility device or appliance.

Acute Respiratory Distress Syndrome (ARDS) means acute respiratory failure independent of clinical heart failure or acute lung injury that occurs when fluid builds up in the air sacs of the lungs, resulting in inadequate oxygenation of the body.

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.

Amyotrophic Lateral Sclerosis (ALS) means a motor neuron disease marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex. Amyotrophic lateral sclerosis (ALS) is commonly referred to as “Lou Gehrig’s Disease.”

Aneurysm means a balloon-like bulge or weakening in the walls of an artery. Aneurysm includes:
1) Abdominal Aortic Aneurysm;
2) Thoracic Aortic Aneurysm; and
3) Other Dissecting or Ruptured Aneurysm.

Aneurysm does not include an aneurysm caused by trauma.

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

Benefit Separation Period means the period of time that must elapse between the dates of Diagnoses of Critical Illnesses for a Covered Person in order for a benefit to be payable for a subsequent Critical Illness.

Benign Brain or Spinal Cord (Intradural) Tumor means a non-cancerous tumor that is located and originates in the:
1) brain, cranial nerves or on the meninges that protect the brain; or
2) spinal cord (intradural).

A benign brain or spinal cord (intradural) tumor does not include:
1) any tumor resulting from neurofibromatosis, tuberous sclerosis or Von Hippel-Lindau disease if Diagnosed prior to a Covered Person's effective date of coverage under the Policy;
2) tumors of the skull, vertebrae or peripheral nerves;
3) pituitary adenomas less than 1 cm; or
4) angiomas or aneurysms.

Bone Marrow Failure means the irreversible failure of the bone marrow's ability to produce enough healthy blood cells to maintain the body's needs, for which a Physician has determined that an autologous or allogeneic transplant of bone marrow or stem cells is medically necessary.

Cancer (Invasive) means a disease identified by the presence of malignant cells or a malignant tumor, characterized by the abnormal and uncontrolled growth and spread of invasive malignant cells or an invasive malignant tumor to tissue beyond the tissue of origin. Cancer includes (but is not limited to) the following:
1) lymphoma classified as stage II or higher, symptomatic myeloma and sarcoma;
2) acute forms of leukemia, chronic myeloid leukemia classified as accelerated or blast phase, or chronic lymphocytic leukemia classified as Rai Stage I or Binet Stage B or greater;
3) any cancer of the breast, including those classified as stage 0 or in situ;
4) Other Skin Malignancy classified as AJCC Stage IV or greater; and
5) malignant melanoma classified as AJCC Stage II or greater.

Cancer does not include:
1) Carcinoma in Situ (Non-Invasive);
2) Skin Cancer;
3) Premalignant Conditions; or
4) other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential.

Carcinoma in Situ (Non-Invasive) means a group of abnormal cells that have not yet become invasive and are confined to the tissue of origin without having invaded neighboring tissue or regional lymph nodes, typically classified as AJCC Stage 0 or in situ cancer. Carcinoma in situ includes (but is not limited to) the following:
1) early prostate cancer classified as AJCC Stage T1N0M0;
2) lymphoma classified as stage I or lower and asymptomatic myeloma;
3) chronic myeloid leukemia classified as chronic phase;
4) chronic lymphocytic leukemia classified as Rai Stage 0 or Binet Stage A;
5) Other Skin Malignancy classified as AJCC Stage II or III; and
6) malignant melanoma that has been classified as AJCC Stage I.

Carcinoma in situ does not include:
1) Skin Cancer;
2) Premalignant Conditions; or

3) other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential.

Cerebral Palsy means the group of non-progressive disorders of movement and posture caused by abnormal development of or damage to the motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth that results in:

1) significant disturbances of sensation, cognition, communication, perception and/or behavior;
2) a seizure disorder; or
3) for older children, inability to independently perform age-appropriate Activities of Daily Living (ADLs).

Other conditions similar to cerebral palsy such as:

1) coagulation, degenerative nervous or metabolic disorders;
2) genetic or muscle diseases;
3) nervous system tumors; or
4) other injuries or disorders which delay early development (but can be outgrown);

must be ruled out and are not included in this definition.

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

Change in Family Status means one of the following events:

1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
2) You and Your Spouse divorce or legally terminate Your relationship;
3) Your Spouse dies;
4) You acquire a child who satisfies the definition of Dependent Child;
5) Your child no longer satisfies the definition of a Dependent Child or dies;
6) Your Spouse is no longer employed, which results in a loss of 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.

Childhood means any biological age from live birth through age 12.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results. The date of Diagnosis for a clinical diagnosis is the earliest of:

1) the date a Physician confirms an illness or condition exists;
2) the date a medical or diagnostic test proves an illness or condition exists; or
3) the date a Physician recommends a form of Treatment for an illness or condition (if applicable).

Coma means a continuous state of profound unconsciousness with no reaction to external stimuli or response to internal needs. A coma must:

1) be the result of illness or disease;
2) last for a continuous period of 7 days or longer;
3) require intubation for respiratory assistance; and
4) be classified with a Glasgow Coma Scale score of 8 or less (or equivalent).

A coma does not include a medically induced coma or a coma caused or contributed to by: Substance Use Disorder; a Stroke; or an Accident.

Complete Remission/No Evidence of Disease means that tests, physical exams and scans show no evidence that any cancer or tumor cells remain in the body.

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

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

Congenital Anomalies 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. 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.

Congenital Heart Defect means any of the following:
1) atresia of any heart valve;
2) coarctation of the aorta;
3) double outlet left or right ventricle;
4) Ebstein's anomaly;
5) Eisenmenger syndrome;
6) hypoplastic left heart syndrome;
7) patent ductus arteriosis;
8) single ventricle;
9) tetralogy of Fallot;
10) total anomalous pulmonary venous connection;
11) transposition of the great arteries;
12) truncus arteriosus; or
13) any other congenital heart defect for which Surgery is recommended to sustain life.

Congenital Metabolic Disorder means any of the following:
1) Gaucher's disease types 2 and 3;
2) glutaric acidemia type 1;
3) glycogen storage disease type II (also known as Pompe disease) and IV (also known as Andersen Disease);
4) infantile or juvenile GM2 gangliosidoses, including:
    a) hexosaminidase activator deficiency;
    b) Sandhoff disease; or
    c) Tay-Sachs disease;
5) Lesch Nyhan syndrome;
6) Niemann-Pick disease; or
7) Zellweger syndrome (excluding other Zellweger spectrum disorders).

Congenital metabolic disorder does not include any condition not listed in this definition.

Coronary Artery Disease means the narrowing or blockage of at least 50% of one or more coronary arteries.

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

Critical Illness means any of the conditions shown in the Benefit Schedule for which a Covered Person is Diagnosed while coverage is in effect under the Policy.

Critical Illness Category means a category assigned to a group of Critical Illnesses as shown in the Benefit Schedule.

Dementia means a permanent, progressive neurological condition that results in memory impairment and cognitive decline. Dementia includes:
1) Alzheimer's disease;
2) corticobasal degeneration;
3) dementia with Lewy bodies;
4) frontotemporal dementia;
5) Parkinson's disease dementia;
6) primary progressive aphasia;
7) progressive supranuclear palsy; or
8) rapidly progressive dementia such as Creutzfeldt-Jakob disease.

Dementia does not include:
1) any form of dementia that is a mental condition, such as schizophrenia or psychoses;
2) any form of Parkinson's disease other than Parkinson's disease dementia;
3) reversible dementias, such as those caused by thyroid abnormalities, other hormonal abnormalities or vitamin deficiencies; or
4) substance-induced conditions.

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

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

who is/are under 26 years of age.

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

and proof has been provided of their disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist. Such proof will be required at the time of claim, and in no event more than once per year thereafter.

Diagnosed, Diagnosis means the definitive establishment of a Critical Illness by a Physician through the use of clinical or pathological findings, made in accordance with generally accepted medical principles and professional medical standards.

Dissecting Aneurysm means a condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall.

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

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 Participating Employer on a regular basis in the usual course of the Participating Employer's business.

This definition does not include a person working for the Participating Employer:
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 Participating Employer 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.

End Stage Renal Disease (ESRD) means the chronic and irreversible failure of both kidneys to function. End stage renal disease (ESRD) does not include kidney failure caused by a traumatic event or surgical trauma.

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

Genetic Disorder means any of the following:
1) cystic fibrosis;
2) infantile onset ascending spastic paralysis;
3) Down syndrome;
4) juvenile primary lateral sclerosis;
5) muscular dystrophy;
6) osteogenesis imperfecta (excluding type 1);
7) sickle cell anemia (excluding sickle cell trait);
8) spinal muscular atrophy types 0, 1, 2 and 3; or

9) vascular Ehlers-Danlos syndrome.

Genetic disorder does not include any condition not listed in this definition.

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

Health Screening Test means:
1) a dental exam, eye exam or hearing exam conducted by a Physician or Medical Professional;
2) an annual physical, sports physical or well child exam conducted by a Physician or Medical Professional;
3) an employer-sponsored wellness or biometric screening;
4) a serum cortisol test (for stress levels) recommended or prescribed by a Physician or Medical Professional and conducted in a clinical setting;
5) any immunization received from a Physician or Medical Professional or received in a clinical setting; or
6) any of the following screening tests recommended or prescribed by a Physician or Medical Professional and conducted in a clinical setting: Aneurysm ultrasound; blood test for triglycerides; bone marrow testing; bone density screening; breast ultrasound; CA 15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); carotid ultrasound; CEA (blood test for colon cancer); cervical cancer screening; chest X-ray; colonoscopy; COVID-19 testing; CT angiography; ECG/EKG; double contrast barium enema; fasting blood glucose test; flexible sigmoidoscopy; hemoccult stool analysis; lipid panel; mammography; pap smear; PAD ultrasound; PSA (blood test for prostate cancer); serum cholesterol test (for HDL and LDL levels); SPEP (blood test for myeloma); stress test (on a bicycle or treadmill); thermography; or any other generally medically accepted screening test for a Critical Illness.

Heart Attack (Myocardial Infarction) means a condition that occurs when a severe and sudden loss of adequate blood supply to part of the heart muscle causes damage to the heart muscle. Heart attack (myocardial infarction) includes:
1) ST-Segment Elevation Myocardial Infarction (STEMI); and
2) Non-ST Segment Elevation Myocardial Infarction (NSTEMI).

Heart attack (myocardial infarction) does not include:
1) other acute coronary syndromes (including but not limited to unstable angina or coronary artery spasm);
2) any other disease or Injury involving the cardiovascular system;
3) any established (old) myocardial infarction;
4) any heart attack that occurs during a Surgical Procedure or any other clinical procedure;
5) any heart attack that is the result of Substance Use Disorder; or
6) cardiac arrest not caused by a myocardial infarction, such as Sudden Cardiac Arrest.

Home Office means Our office at One Hartford Plaza, Hartford, CT 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; and
3) providing 24-hour nursing service by or under the supervision of registered nurses (RNs).

Hospital does not include:
1) convalescent homes, or convalescent, rest or nursing facilities;
2) facilities affording primarily custodial, educational or rehabilitory care; or
3) facilities primarily for care of the aged/elderly, care of persons with Substance Use Disorders, or care of persons with Mental Health Disorders.

Initial Occurrence means the first Diagnosis of a Critical Illness for a Covered Person for which a benefit is payable or was previously paid under the Policy.

Injury or Injuries means bodily damage or harm which requires Treatment by a Physician or Medical Professional.

Loss of Hearing means permanent loss of hearing in both ears caused by an illness or disease:

1) with an aided hearing loss range of 71 decibels (dB HL) or higher (unable to hear sound at or below 70 dB HL); and
2) that cannot be improved or corrected to any greater functional degree by any aid, procedure or device.

Loss of hearing does not include loss of hearing caused or contributed to by an Accident.

Loss of Sight means permanent loss of sight in both eyes caused by an illness or disease:
1) with no realistic expectation of improvement; and
2) with best correction of either eye, visual acuity must be less than 6/60 (metric acuity) or 20/200 (Snellen chart or E chart acuity); or
3) the field of vision must be less than 20 degrees in both eyes.

Loss of sight does not include loss of sight caused or contributed to by an Accident.

Loss of Speech means the total and permanent loss of audible voice communication that cannot be corrected to any functional degree by any aid, procedure or device.

Loss of speech does not include loss of speech caused or contributed to by Stroke, Cancer (Invasive) or an Accident.

Maintenance Drug Therapy means ongoing hormonal therapy, immunotherapy, chemo-prevention therapy or other similar therapy that is intended to decrease the risk of reoccurrence of a cancer or tumor.

Major Organ Failure means the irreversible failure due to end-stage organ disease of the heart, liver, lung, pancreas, small intestine or large intestine.

Major organ failure does not include the failure of any:
1) major organ as a direct result of life-threatening cancer; or
2) other organs, parts of organs, tissues or cells not listed in this definition.

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

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

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

Mild Stroke means a Stroke with neurological deficits that is categorized:
1) with a score of 1 through 4 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event;
2) with a score of 1 or 2 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or
3) as a mild Stroke on any other stroke assessment scale administered in accordance with current medically accepted standards.

Mild stroke does not include Transient Ischemic Attack (TIA).

Moderate Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized:
1) with a score of 5 through 14 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event;
2) with a score of 3 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or
3) as a moderate stroke on any other stroke assessment scale administered in accordance with current medically accepted standards.

Moderate stroke does not include Transient Ischemic Attack (TIA).

Mosquito-Borne Disease means any of the following: chikungunya fever (also known as chikungunya virus infection); malaria; Severe Dengue; West Nile fever; Zika fever (also known as Zika virus disease); and yellow fever.

Multiple Sclerosis (MS) means a progressive neurological condition in which the immune system attacks the protective covering of nerves (myelin) that results in:

1) impairment of motor function and other neurological abnormalities lasting for a continuous period of 6 months or longer; and
2) lesions or demyelination in one or more areas of the central nervous system.

Non-ST Segment Elevation Myocardial Infarction (NSTEMI) means a type of myocardial infarction:

1) in which a coronary artery is only partially or temporarily blocked;
2) which appears in new and serial characteristic electrocardiographic (EKG) changes not inclusive of ST segment elevation; and
3) following which elevation of cardiac enzymes or troponins can be detected in the blood above standard laboratory levels of normal.

Non-ST segment elevation myocardial infarction (NSTEMI) includes a subendocardial infarction, also known as a "non-Q-wave heart attack."

Open Surgery means a Surgical Procedure wherein internal tissues and structures are exposed through an incision to the air and the surgeon has direct sight of the damaged area.

Other Skin Malignancy means basal cell carcinoma, cutaneous lymphoma, merkel cell carcinoma and squamous cell carcinoma.

Parkinson's Disease means a chronic, slowly progressive neurological condition affecting the brain's ability to produce dopamine resulting in tremor, slow movement (bradykinesia), rigid muscles, impaired posture and balance, gait disturbance and/or deterioration of other mental functions.

Parkinson's disease does not include:

1) other Parkinsonian syndromes;
2) Parkinson's disease dementia; or
3) substance-induced conditions.

Pathological Diagnosis means a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. The date of Diagnosis for a pathological diagnosis is the date the tissue specimen, blood samples, titers, cultures or preparations are taken on which the eventual Diagnosis is based.

Permanent Neurological Deficit(s) means any of the following deficits:

1) cognitive impairment;
2) impaired or loss of vision, hearing or the ability to speak or otherwise communicate;
3) balance disruption; or
4) impaired or loss of ability to independently ambulate;

which are expected to be permanent as determined by a Physician.

Permanent Paralysis means damage to the brain or spinal cord caused by an illness or disease that:

1) results in total and irrevocable loss of extremity movement and muscle function of two or more limbs; and
2) has lasted for a continuous period of 90 days or longer and is expected to be permanent; or
3) is known to be permanent with no expectation of a return to function for any limb.

Permanent paralysis does not include paralysis caused or contributed to by a Stroke or an Accident.

Physician means a person who is:

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

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

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

Premalignant Conditions means:

1) anal, cervical, vulvar or vaginal intraepithelial neoplasia for which a Physician has determined that a resection or ablation procedure is medically necessary;
2) atypical hyperplasia of the breast;
3) esophageal or gastric dysplasia for which a Physician has determined that a resection or ablation procedure is medically necessary;
4) intestinal adenoma:
    a) larger than 1 cm with high-grade dysplasia; or
    b) for which a Physician has determined that a bowel resection is medically necessary; and
5) myelodysplastic syndrome or myeloproliferative disorder confirmed by a hematologist through bone marrow examination.

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

Related means a Critical Illness that:

1) is not a Reoccurrence, metastasis, progression or more severe form of any previously Diagnosed Critical Illness; and
2) is directly caused or contributed by, or is a complication of, a previously Diagnosed Critical Illness.

Reoccurrence means another Diagnosis of the same Critical Illness for a Covered Person for which We have previously paid a benefit. A metastasis, progression or more severe form of a previously Diagnosed Critical Illness is not a reoccurrence.

Ruptured Aneurysm means a condition in which an Aneurysm bursts and causes bleeding inside the body.

Severe Dengue means dengue hemorrhagic fever and dengue shock syndrome.

Severe Infectious Disease means a severe infectious or contagious disease that results in symptoms of the disease that require Treatment by a Physician other than diagnostic exams or testing. Severe infectious diseases include:

1) anthrax;
2) Asian H5N1 (formally Highly Pathogenic Asian Avian Influenza A H5N1);
3) brucellosis;
4) cholera;
5) COVID-19 (formally SARS-CoV-2/2019-nCoV);
6) diphtheria;
7) Ebola virus disease;
8) encephalitis;
9) flesh-eating disease (formally necrotizing fasciitis);
10) hantavirus pulmonary syndrome;
11) histoplasmosis;
12) invasive pneumococcal disease (formally streptococcus pneumoniae);
13) leptospirosis;
14) mad cow disease (formally variant Creutzfeldt-Jakob disease (vCJD));
15) meningitis;
16) Middle East respiratory syndrome (formally MERS-CoV (MERS));
17) Mosquito-Borne Disease;
18) osteomyelitis;
19) polio (formally poliomyelitis);
20) rabies;
21) Reye’s syndrome;
22) severe acute respiratory syndrome (formally SARS-CoV (SARS));
23) tetanus;
24) Tick-Borne Disease;
25) tuberculosis;
26) typhoid fever; and

27) whooping cough (formally pertussis).

A severe infectious disease does not include any condition:
1) not listed in this definition; or
2) listed in this definition for which a Covered Person is asymptomatic.

Severe Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized:
1) with a score of 15 or greater on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event;
2) with a score of 4 or greater on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or
3) as a severe or very severe Stroke on any other stroke assessment scale administered in accordance with current medically accepted standards.

Severe stroke does not include Transient Ischemic Attack (TIA).

Skin Cancer means:
1) Other Skin Malignancies classified as AJCC Stage I or lower; or
2) malignant melanoma classified as AJCC Stage 0 or in situ.

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

Stroke means an acute cerebral vascular incident that occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen or nutrients, caused by any of the following:
1) hemorrhage;
2) thrombus; or
3) embolus from an extra-cranial source;

that results in neurological impairment or deficit. Stroke includes:
1) Mild Stroke;
2) Moderate Stroke; and
3) Severe Stroke.

Stroke does not include:
1) ischemic disorders of the vestibular system;
2) brain Injury related to trauma or infection; or
3) brain Injury associated to hypoxia/anoxia or hypotension.

Structural Congenital Defect means any of the following:
1) anal atresia;
2) biliary atresia;
3) cleft lip or palate;
4) club foot;
5) diaphragmatic hernia;
6) gastroschisis;
7) Hirschsprung's disease;
8) omphalocele;
9) pyloric stenosis; or
10) spina bifida (excluding spina bifida occulta).

Structural congenital defect does not include any condition not listed in this definition.

ST-Segment Elevation Myocardial Infarction (STEMI) means a type of myocardial infarction:
1) in which a coronary artery is completely blocked resulting in death of a portion of the heart muscle;
2) which appears in new and serial characteristic electrocardiographic (EKG) changes inclusive of ST segment elevation; and
3) following which there is a characteristic rise of cardiac enzymes, biochemical cardiac markers or troponins recorded at the following levels or higher:
    a) Troponin T > 200 ng/L (0.2 ng/ml or 0.2 ug/L);
    b) Troponin I > 500 ng/L (0.5 ng/ml or 0.5 ug/L); or
    c) equivalent threshold with other methods.

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

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness that occurs when the heart, abruptly and without warning, stops working as the result of an internal electrical disturbance of the heart.

Sudden cardiac arrest does not include:
1) a Heart Attack (Myocardial Infarction); or
2) any sudden cardiac arrest that occurs during a Surgical Procedure or any other clinical procedure.

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

Thoracic Aortic Aneurysm means an Aneurysm located in the thoracic (upper) part of the aorta that is:
1) 5 centimeters or larger in size;
2) less than 5 centimeters and is rapidly expanding; or
3) a Dissecting Aneurysm or a Ruptured Aneurysm.

Tick-Borne Disease means any of the following: anaplamosis; babesiosis; borrelia miyamotoi disease; borrelia mayonii disease; Bourbon virus; Colorado tick fever; ehrlichiosis; Heartland virus; lyme disease (formally borreliosis); Powassan virus; rickettsia parkeri rickettsiosis; Rocky Mountain spotted fever (RMSF); southern tick-associated rash illness (STARI); tickborne relapsing fever; and tularemia.

Transient Ischemic Attack (TIA) means a brief episode of neurologic dysfunction caused by focal brain or retinal ischemia with clinical symptoms typically lasting less than one hour, without evidence of acute infarction. A transient ischemic attack is commonly referred to as a "mini-stroke."

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. For any Critical Illness included in the Cancer & Benign Tumor Category, following a declaration of Complete Remission/No Evidence of Disease by the primary treating Physician for a prior diagnosis of a Critical Illness, this definition does not include:
1) routine follow-up visits or assessments with a Physician or Medical Professional to verify whether or not the Critical Illness has returned; or
2) Maintenance Drug Therapy.

Unrelated means a Critical Illness that is:
1) not a Reoccurrence of any previously Diagnosed Critical Illness;
2) not a metastasis, progression or more severe form of a previously Diagnosed Critical Illness; and
3) distinct in the cause and etiology from, and is not a complication of, a previously Diagnosed Critical Illness.

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

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

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

ELIGIBILITY & EFFECTIVE DATES

Eligibility for Coverage
An Employee will become eligible for coverage under the Policy on the latest of:
1) the Participating Employer Effective Date;
2) the date they become a member of an Eligible Class; or
3) the date they complete the Eligibility Waiting Period.

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

2) the date You acquire the Dependent.

If 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 January 1st following the last day of an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or
4) the first day of the month following the date an Employee or Dependent is enrolled.

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

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

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

All Coverage Effective Dates, Changes in Coverage effective dates, New Dependent Coverage effective dates and Reinstatement of Coverage effective dates for a Dependent will also be deferred if on the date the Dependent is to become covered, they are Confined or Confined Elsewhere. Such coverage will not start until the day after the Dependent:
1) is no longer Confined or Confined Elsewhere; and
2) has engaged in all of the normal and customary activities of a person of like age, gender and good health for at least 15 consecutive days.

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

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

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

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

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

subject to the Deferred Coverage Effective Date provision.

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

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

New Dependent Coverage

If You:

1) marry; or
2) acquire a child who satisfies the definition of Dependent Child(ren);

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

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

TERMINATION OF COVERAGE

Termination of Coverage

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

1) the last day of the month during which You become no longer eligible for insurance under any provision of the Policy;
2) the last day of the month during which You are no longer in an Eligible Class or the Policy no longer covers Your class;
3) the last day of the month during which You request We terminate coverage, subject to the Changes in Coverage provision;
4) the date the required premium is due but not paid; or
5) the date the Policy terminates or the Participating Employer ceases to participate in the Policy.

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

When coverage would otherwise end, You or an insured Spouse, in certain circumstances may be able to continue insurance:

1) under a Continuation provision; or
2) under the Extended Continuation provision.

Termination of coverage has no effect on benefits payable for a Critical Illness that is Diagnosed or Treatment that is received 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 month(s) from the date coverage ended; and
2) requests reinstatement within 31 days from their return to an Eligible Class, if coverage requires an election under the Policy;

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

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

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

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

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

CONTINUATION

CONTINUATION

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

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:
1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf); and
2) the Participating Employer must approve the continuation.

Coverage continued under this provision will end on the last day of the month on or next following the earliest of the day:
1) the applicable continuation time period has expired, as described in the Continuation Option(s);
2) You return to Active Work for the Participating Employer; or
3) You begin full-time employment with an employer other than the Participating Employer.

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

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

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 Participating Employer, including retirement.

If You are eligible to continue coverage under this provision, then You must elect insurance under this provision in order

for any Dependent(s) to remain eligible for coverage.

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

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

If an insured Spouse continues coverage under this provision, the Spouse will become a Primary Insured going forward. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

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

The request and the initial premium due must be received within 31 days after insurance under the Policy would otherwise end. If timely notice is not given, an extension of the period of time in which to request continued coverage under this provision will be allowed. You or Your Spouse will have 15 days from the date notice is received to submit the request and initial premium. However, in no event will a request be accepted by Us if received more than 91 days after the date coverage under the Policy would otherwise end, even if notice is not received.

Coverage continued under this provision:

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

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

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.

CRITICAL ILLNESS BENEFITS

CANCER & BENIGN TUMOR CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Cancer & Benign Tumor Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Cancer & Benign Tumor Category if a Covered Person was Diagnosed with such illness or condition prior to the Covered Person's effective date of coverage under the Policy. In addition, We will not pay benefits for any Critical Illness included in the Cancer & Benign Tumor Category if the Critical Illness is a progression or metastasis of an illness or condition that was Diagnosed for a Covered Person prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit
We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:

1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Cancer & Benign Tumor Category; or

2) when a Covered Person is Diagnosed with a Critical Illness included in the Cancer & Benign Tumor Category that is:
    a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
    b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Cancer & Benign Tumor Category for which an Initial Occurrence Benefit was previously paid by Us, and:
1) that Critical Illness is subsequently Diagnosed as a more advanced or metastasized condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Reoccurrence Benefit
We will pay the applicable Reoccurrence Benefit Amount shown in the Benefit Schedule for another Diagnosis of the same Critical Illness for a Covered Person in the Cancer & Benign Tumor Category for which a benefit was previously paid under the Policy if:
1) the Reoccurrence Benefit Separation Period has been satisfied; and
2) there is a declaration of Complete Remission/No Evidence of Disease for a Covered Person by the primary treating Physician for the prior Diagnosis of the same Critical Illness.

A Reoccurrence Benefit is only payable once per Critical Illness in the Cancer & Benign Tumor Category.

Additional Requirements
For **Cancer (Invasive)**, **Carcinoma in Situ (Non-Invasive)**, **Skin Cancer** or **Bone Marrow Failure**, the following will be required for Proof of Loss:
1) a Pathological Diagnosis; or
2) a Clinical Diagnosis only if a Pathological Diagnosis cannot be made because it would be medically inappropriate or life threatening, based on the following:
    a) medical evidence or diagnostic testing that supports the Diagnosis; and
    b) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met.

For the **Early Diagnosis** of a **Benign Brain or Spinal Cord (Intradural) Tumor**, the following will be required for Proof of Loss:
1) a Pathological Diagnosis and results of any neuroradiology exams (CT scan, MRI or other reliable imaging techniques); or
2) a Clinical Diagnosis only if a Pathological Diagnosis cannot be made because it would be medically inappropriate or life threatening, based on the following:
    a) medical evidence or diagnostic testing that supports the Diagnosis; and
    b) a Physician is treating the Covered Person for a Benign Brain or Spinal Cord (Intradural) Tumor;

that demonstrates that the definition of Benign Brain or Spinal Cord (Intradural) Tumor has been met for which:
1) neurological deficits have been observed and documented by a Physician; and
2) Surgery or radiation therapy is not currently recommended by a Physician for Treatment.

For the **Advanced Diagnosis** of a **Benign Brain or Spinal Cord (Intradural) Tumor**, the following will be required for Proof of Loss:
1) a Pathological Diagnosis and results of any neuroradiology exams (CT scan, MRI or other reliable imaging techniques); or
2) a Clinical Diagnosis only if a Pathological Diagnosis cannot be made because it would be medically inappropriate or life threatening, based on the following:
    a) medical evidence or diagnostic testing that supports the Diagnosis; and
    b) a Physician is treating the Covered Person for a Benign Brain or Spinal Cord (Intradural) Tumor;

that demonstrates that the definition of Benign Brain or Spinal Cord (Intradural) Tumor has been met:
1) for which Surgery or radiation therapy is recommended by a Physician for Treatment; or
2) resulting in one or more Permanent Neurological Deficits attributable to the Benign Brain or Spinal Cord (Intradural) Tumor.

Any requirement for recommendation of Surgery or a Surgical Procedure for Treatment of a Critical Illness will be waived if a Covered Person is too ill to undergo the procedure, but the procedure would otherwise be recommended due to the severity of the Critical Illness.

Unless otherwise stated, in the event of death an autopsy confirmation or death certificate identifying a Critical Illness included in the Cancer & Benign Tumor Category as the sole or primary cause of death will be accepted as Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

HEART & VASCULAR CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Heart & Vascular Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Heart & Vascular Category if a Covered Person was Diagnosed with such illness or condition prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit
We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:

1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Heart & Vascular Category; or
2) when a Covered Person is Diagnosed with a Critical Illness included in the Heart & Vascular Category that is:
    a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
    b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Heart & Vascular Category for which an Initial Occurrence Benefit was previously paid by Us, and:

1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Reoccurrence Benefit
We will pay the applicable Reoccurrence Benefit Amount shown in the Benefit Schedule for another Diagnosis of the same Critical Illness for a Covered Person in the Heart & Vascular Category for which a benefit was previously paid under the Policy, if the Reoccurrence Benefit Separation Period has been satisfied. A Reoccurrence Benefit is only payable once per Critical Illness in the Heart & Vascular Category.

Additional Requirements
For **Heart Attack (Myocardial Infarction)**, the following will be required for Proof of Loss:

1) a Pathological Diagnosis and results of any cardiac exams (EKG, echocardiogram, MRI or other reliable tests or imaging techniques); or
2) a Clinical Diagnosis only if a Pathological Diagnosis cannot be made because it would be medically inappropriate or life threatening, based on the following:
    a) medical evidence or diagnostic testing that supports the Diagnosis; and
    b) a Physician is treating the Covered Person for a Heart Attack (Myocardial Infarction);

that demonstrates that the definition of the applicable Critical Illness has been met.

For the **Minor Diagnosis** of **Coronary Artery Disease**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, for which an endovascular or minimally invasive Surgical Procedure is recommended by a Physician for Treatment, will be required for Proof of Loss.

For the **Major Diagnosis** of **Coronary Artery Disease**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, for which major Surgery requiring median sternotomy (surgery to divide the breastbone) is recommended by a Physician for Treatment, will be required for Proof of Loss.

For **Stroke**, the following will be required for Proof of Loss:

1) results of neuroimaging studies (CT scan, MRI or other reliable imaging techniques) confirming a new Stroke;
2) medical records or evidence indicating new neurological deficits or impairment as a result of the Stroke; and
3) confirmation by a Physician of the applicable Stroke assessment categorization(s);

that demonstrates that the definition of the applicable Critical Illness has been met.

For the **Major Diagnosis** of an **Aneurysm**, a Clinical Diagnosis based on the following:

1) results of imaging studies (ultrasound, angiogram, CT scan, MRI or other reliable imaging techniques) confirming the Aneurysm; and
2) a Physician is treating the Covered Person for the Aneurysm;

that demonstrates that the applicable definition of Aneurysm has been met, for which Open Surgery is recommended by a Physician for Treatment, will be required for Proof of Loss.

Any requirement for recommendation of Surgery or a Surgical Procedure for Treatment of a Critical Illness will be waived if a Covered Person is too ill to undergo the procedure, but the procedure would otherwise be recommended due to the severity of the Critical Illness.

Unless otherwise stated, in the event of death an autopsy confirmation or death certificate identifying a Critical Illness included in the Heart & Vascular Category as the sole or primary cause of death will be accepted as Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

MAJOR ORGAN CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Major Organ Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Major Organ Category if a Covered Person was Diagnosed with such illness or condition prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:

1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Major Organ Category; or
2) when a Covered Person is Diagnosed with a Critical Illness included in the Major Organ Category that is:
   a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
   b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Major Organ Category for which an Initial Occurrence Benefit was previously paid by Us, and:

1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or

2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Reoccurrence Benefit

We will pay the applicable Reoccurrence Benefit Amount shown in the Benefit Schedule for another Diagnosis of the same Critical Illness for a Covered Person in the Major Organ Category for which a benefit was previously paid under the Policy, if the Reoccurrence Benefit Separation Period has been satisfied. A Reoccurrence Benefit is only payable once per Critical Illness in the Major Organ Category.

Additional Requirements

For **Major Organ Failure**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for Major Organ Failure;

that demonstrates that the definition of Major Organ Failure has been met, for which the complete or partial replacement of the organ through transplant from a human donor is recommended by a Physician for Treatment, will be required for Proof of Loss.

For **End Stage Renal Disease (ESRD)**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for End Stage Renal Disease (ESRD);

that demonstrates that the definition of End Stage Renal Disease (ESRD) has been met, for which:

1) regular (at least weekly) dialysis to sustain life; or
2) the replacement of a kidney through transplant from a human donor;

is recommended by a Physician for Treatment, will be required for Proof of Loss.

For the Diagnosis of **Acute Respiratory Distress Syndrome (ARDS)**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, will be required for Proof of Loss.

Any requirement for recommendation of Surgery or a Surgical Procedure for Treatment of a Critical Illness, including transplant, will be waived if a Covered Person is too ill to undergo the procedure but the procedure would otherwise be recommended due to the severity of the Critical Illness.

Unless otherwise stated, in the event of death an autopsy confirmation or death certificate identifying a Critical Illness included in the Major Organ Category as the sole or primary cause of death will be accepted as Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

NEUROLOGICAL CONDITIONS CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Neurological Conditions Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Neurological Conditions Category if a Covered Person was Diagnosed with such illness or condition, regardless of symptoms, severity or incapacity, prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:

1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Neurological Conditions Category; or

2) when a Covered Person is Diagnosed with a Critical Illness included in the Neurological Conditions Category that is:
    a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
    b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Neurological Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and:
1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Additional Requirements

For the **Advanced Diagnosis** of **Dementia**, a Clinical Diagnosis based on the following:
1) medical evidence, cognitive testing or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for Dementia;

that demonstrates that the definition of Dementia has been met, for which cognitive deficits are moderate or severe, consistent with:
1) a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 4 or higher; or
2) Clinical Dementia Rating Scale (CDR) score of 2 or higher;

resulting in the Covered Person's long-term (a continuous period of 90 days or longer) or permanent inability to perform 2 or more Activities of Daily Living (ADLs), will be required for Proof of Loss.

For the **Advanced Diagnosis** of:
1) **Parkinson's Disease**;
2) **Amyotrophic Lateral Sclerosis (ALS)**; or
3) **Multiple Sclerosis (MS)**;

a Clinical Diagnosis based on the following:
1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, resulting in the Covered Person's long-term (a continuous period of 90 days or longer) or permanent inability to perform 2 or more Activities of Daily Living (ADLs), will be required for Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

INFECTIOUS CONDITIONS CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Infectious Conditions Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Infectious Conditions Category if a Covered Person was Diagnosed with such illness or condition, regardless of symptoms, severity or incapacity, prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:
1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Infectious Conditions Category; or
2) when a Covered Person is Diagnosed with a Critical Illness included in the Infectious Conditions Category that is:
    a) Unrelated to any Critical Illness for which We have previously paid a benefit; or

b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Infectious Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and:

1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Additional Requirements

For the **Major Diagnosis** of a **Severe Infectious Disease**, a Clinical Diagnosis based on the following:

1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Severe Infectious Disease;

that demonstrates that the definition of the applicable Severe Infectious Disease has been met, that results in a Covered Person being Confined to a Hospital for 5 or more consecutive days, will be required for Proof of Loss.

Unless otherwise stated, in the event of death an autopsy confirmation or death certificate identifying a Critical Illness included in the Infectious Conditions Category as the sole or primary cause of death will be accepted as Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

FUNCTIONAL LOSS & CATASTROPHIC CONDITIONS CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Functional Loss & Catastrophic Conditions Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Functional Loss & Catastrophic Conditions Category if a Covered Person was Diagnosed with such illness or condition, regardless of symptoms or severity, prior to the Covered Person's effective date of coverage under the Policy.

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:

1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Functional Loss & Catastrophic Conditions Category; or
2) when a Covered Person is Diagnosed with a Critical Illness included in the Functional Loss & Catastrophic Conditions Category that is:
   a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
   b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Functional Loss & Catastrophic Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and:

1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 30 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Reoccurrence Benefit for Coma
We will pay the applicable Reoccurrence Benefit Amount shown in the Benefit Schedule for another Diagnosis of a Coma for a Covered Person if a benefit for a Coma was previously paid under the Policy, if the Reoccurrence Benefit Separation Period has been satisfied. A Reoccurrence Benefit is only payable once for Coma.

Additional Requirements
For the Diagnosis of:
1) **Coma**;
2) **Loss of Hearing**;
3) **Loss of Sight**;
4) **Loss of Speech**; or
5) **Permanent Paralysis**;

a Clinical Diagnosis based on the following:
1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, will be required for Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

CHILD CONDITIONS CATEGORY BENEFITS

All Critical Illness Benefits are subject to all of the applicable Definitions, Additional Requirements, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

If a Covered Person is Diagnosed with more than one Critical Illness included in the Child Conditions Category at the same time or on the same day for which a benefit is payable, We will only pay the applicable benefit for the Critical Illness that pays the highest benefit amount.

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Child Conditions Category:
1) if a Covered Person was Diagnosed with such illness or condition, regardless of symptoms, severity or incapacity, prior to the Covered Person's effective date of coverage under the Policy; or
2) for the Diagnosis of any Critical Illness for a stillborn child.

Unless otherwise stated, Diagnosis of any Critical Illness in the Child Conditions Category must be made during Childhood. The date of Diagnosis under the Policy for any prenatal Diagnosis is the date of live birth of the Dependent Child.

Initial Occurrence Benefit
We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule:
1) the first time a Covered Person is Diagnosed with a Critical Illness included in the Child Conditions Category; or
2) when a Covered Person is Diagnosed with a Critical Illness included in the Child Conditions Category that is:
   a) Unrelated to any Critical Illness for which We have previously paid a benefit; or
   b) Related to any Critical Illness for which We have previously paid a benefit, if Diagnosed more than 30 days after the date of Diagnosis for the prior Critical Illness.

In the event a Covered Person is Diagnosed with a Critical Illness in the Child Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and:
1) that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable; or
2) the Covered Person is subsequently Diagnosed with a Related Critical Illness within 90 days after the date of Diagnosis for the prior Critical Illness for which a higher benefit is payable;

We will pay any difference in the two amounts as an additional benefit amount.

Additional Requirements
For the **Early Diagnosis** of a **Cerebral Palsy**, a Clinical Diagnosis based on the following:
1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for Cerebral Palsy;

that demonstrates that the definition of Cerebral Palsy has been met, for which the Covered Person is:
1) age 2 or younger; or
2) older than age 2 and is classified by a Physician as Level I or II on the Gross Motor Function Classification System – Expanded and Revised (GMFCS – E&R);

will be required for Proof of Loss.

For the **Advanced Diagnosis** of **Cerebral Palsy**, a Clinical Diagnosis based on the following:
1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for Cerebral Palsy;

that demonstrates that the definition of Cerebral Palsy has been met, for which the Covered Person is:
1) older than age 2; and
2) is classified by a Physician as Level III or higher on the Gross Motor Function Classification System – Expanded and Revised (GMFCS – E&R);

will be required for Proof of Loss.

For the Diagnosis of:
1) **Congenital Heart Defect**;
2) **Congenital Metabolic Disorder**;
3) **Genetic Disorder**; or
4) **Structural Congenital Defect**;

a Clinical Diagnosis based on the following:
1) medical evidence or diagnostic testing that supports the Diagnosis; and
2) a Physician is treating the Covered Person for the applicable Critical Illness;

that demonstrates that the definition of the applicable Critical Illness has been met, will be required for Proof of Loss.

Any requirements must be documented in Writing by a Physician or in medical records.

ADDITIONAL BENEFIT(S)

All Additional Benefits are subject to all of the applicable Definitions, maximums, limitations, Exclusions and other provisions of the Policy. Please read all sections of this Certificate carefully in order to fully understand each benefit.

The Benefit Amounts shown in the Benefit Schedule may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the following provisions. Insurance must be in effect for a Covered Person at the time the test, screening, evaluation or service is rendered or received by the Covered Person for any Additional Benefits to be payable.

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

As noted in the Benefit Schedule, this benefit is payable once per Policy Year for each Covered Person.

GENERAL LIMITATIONS & EXCLUSIONS

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

Reoccurrence Benefit Separation Period
Once a Critical Illness is Diagnosed for which a benefit is payable for a Covered Person, in order for a Reoccurrence Benefit to be payable for that same Critical Illness, the Reoccurrence Benefit Separation Period shown in the Benefit Schedule must be satisfied.

Policy Benefit Maximum
Each Covered Person may receive multiple payments for Critical Illness Benefits under this Certificate until the Policy Benefit Maximum shown in the Benefit Schedule is reached.

In addition to payments for Critical Illness Benefits under this Certificate, the following will also count toward the Policy Benefit Maximum for any illness or condition that is a Critical Illness under this Certificate:

1) benefits paid under another certificate of critical illness or specified disease insurance issued under the Policy or by Us; or
2) benefits paid under another policy of critical illness or specified disease insurance previously issued to the Participating Employer or You by Us.

Any payments received by a Covered Person for any Additional Benefits do not count toward this maximum.

Exclusions
No benefits are payable under the Policy for any Critical Illness that results from, is caused by or that takes place during a Covered Person's:

1) intentional self-inflicted illness or Injury;
2) voluntarily taking or using any drug, narcotic, medication or sedative, unless it is:
   a) taken or used as prescribed by a Physician; or
   b) taken according to package directions, for any over-the-counter drug, medication or sedative;
3) voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities (except for misdemeanor violations), or voluntary engagement in an illegal occupation;
4) incarceration or imprisonment in any type of penal or detention facility;
5) 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
6) 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.

In addition, no benefits are payable under the Policy for any Critical Illness that results from or is caused by a Covered Person's Substance Use Disorder.

In addition, no benefits are payable under the Policy for any Critical Illness for which Diagnosis is made outside the United States or Canada, unless the Diagnosis is confirmed in the United States. The date of Diagnosis in such circumstances is the date the Diagnosis was originally made outside the United States or Canada.

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.

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 date of:

1) Diagnosis of a Critical Illness for which benefits are sought; or
2) service or treatment for any Additional Benefit for which benefits are sought;

unless the claimant is legally incapacitated.

Physical Examinations and Autopsy
We, at Our own expense, may:

1) examine a Covered Person for whom a claim is made as often as reasonably necessary while a claim is pending; and
2) in cases of death of a Covered Person have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in this State.

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 Your designated beneficiary(ies), or if none, then in the following order to:

1) Your Spouse;
2) Your children;
3) Your parents;
4) Your siblings; or
5) Your estate.

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

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

Change of Beneficiary
The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Participating Employer, 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 Participating Employer, 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 their representative may appeal to Us for a full and fair review. To do so, the claimant:

1) must submit a Written request for review within:
   a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of a Critical Illness or other loss; or
   b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of a Critical Illness or other loss; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit Written comments, documents, records and other information relating to the claim.

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

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

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

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

GENERAL PROVISIONS

Entire Contract
This insurance is provided under a contract of group insurance with the Policyholder. The entire contract between the Policyholder and Us includes the following:
1) the Policy, which includes the Certificate(s) for each Eligible Class of the Policy;
2) the Policyholder's signed application (if any); and
3) any riders, amendments or endorsements to the Policy.

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

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

Legal Actions
No legal action may start:
1) until 60 days after Proof of Loss has been given; or
2) more than 6 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 Your rights and interest under the Policy.

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

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

- With respect to one life, regardless of the number of policies or contracts: $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or
- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

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

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

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

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

Uses and Disclosures of Your PHI

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

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

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

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

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

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

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

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

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

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

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

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

Your Privacy Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Right to be Notified Following a Breach. You have a right to 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 SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST:

   Group Critical Illness Plan

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2. **Plan Number**

   Group Critical Illness - 501

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3. **Employer/Plan Sponsor**

   SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST
   132 WESTPARK BOULEVARD
   COLUMBIA, SC 29210

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4. **Employer Identification Number**

   91-1839164

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Critical Illness Insurance

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6. **Plan Administrator**

   SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST
   132 WESTPARK BOULEVARD
   COLUMBIA, SC 29210

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

   For the Plan

   SOUTH CAROLINA MEDICAL ASSOCIATION MEMBERS INSURANCE TRUST

132 WESTPARK BOULEVARD
COLUMBIA, SC 29210

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 Critical Illness 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 Policy 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 Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

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

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance

Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.