YOUR BENEFIT PLAN

CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN

GROUP RETIREE INSURANCE PLAN®

Questions or Complaints about Your Coverage

In the event You have questions or complaints regarding any aspect of Your coverage, You should contact Your Employee Benefits Manager or You may write to Us at:
Benistar Administrative Services, Inc. (BASI)
10 Tower Lane, First Floor
Avon, CT 06001

Or call Us at: 1-800-236-4782

When calling, please give Us the following information:
1) the Policy number; and
2) the name of the Policyholder (employer or organization), as shown in Your Certificate of Insurance.

Hartford Life and Accident Insurance Company has contracted with an independent Third Party Administrator, to provide administrative services under a Policy issued to Catskill Area Schools Employee Benefit Plan.

The insurance carrier for the Policy is:	The Administrator for the Policy is:
Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, Connecticut 06155	Benistar Administrative Services, Inc. (BASI) 10 Tower Lane, First Floor Avon, CT 06001

If You have a complaint, and contacts between You and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require We provide You with additional contact information:

For residents of:	**Write**	**Telephone**
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904	1(800) 852-5494 1(501) 371-2640 (in the Little Rock area)
California	State of California Insurance Department Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013 Web Address: www.insurance.ca.gov	1(800) 927-HELP
Illinois	Illinois Department of Insurance Consumer Division Springfield, Illinois 62767	Consumer Assistance: 1(866) 445-5364 Officer of Consumer Health Insurance: 1(877) 527-9431

Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1(800) 622-4461 1(317) 232-2395 (in the Indianapolis Area)
Wisconsin	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) to request a complaint form.

The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona This Certificate of Insurance may not provide all benefits and protections provided by law in Arizona. Please read This Certificate carefully.

Florida The benefits of the Policy providing Your coverage are governed primarily by the laws of a state other than Florida.

Georgia

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

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

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

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

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

Texas

IMPORTANT NOTICE	**AVISO IMPORTANTE**
To obtain information or make a complaint:	Para obtener información o para presentar una queja:
You may call The Hartford's toll-free telephone number	Usted puede llamar al número de teléfono gratuito de

for information or to make a complaint at:

1-800-523-2233

You may also write to The Hartford at:

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

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

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

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

The Hartford's para obtener información o para presentar una queja al:

1-800-523-2233

Usted también puede escribir a The Hartford:

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

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007
Sito web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:
Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con el agente o la compañía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:
Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

Virginia

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason, please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions, You may contact the insurance company issuing this insurance at the following address and telephone number: Benistar Administrative Services, Inc. (BASI), 10 Tower Lane, First Floor, Avon, CT 06001**.**

1-800-236-4782

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

1(804) 371-9741 (inside Virginia)
1(800) 552-7945 (inside Virginia only)
1(877) 310-6560 (inside & outside Virginia)

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your Policy Number available.

THE HARTFORD GROUP RETIREE INSURANCE PLAN®
CERTIFICATE OF GROUP RETIREE HEALTH INSURANCE

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: Catskill Area Schools Employee Benefit Plan
Policy Number: AGP-003951
Policy Effective Date: January 1, 2018
Policy Anniversary Date: January 1

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

Signed for the Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

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

Notice to buyer: The Policy may not cover all of the costs associated with medical care received during the period of coverage. Please review carefully all of The Policy's limitations contained in this Certificate.

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

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SCHEDULE

ELIGIBLE CLASSES FOR COVERAGE

Class	Description of Eligible Persons:
I	Retirees, and their Medicare Eligible Dependents, entitled to Medicare benefits.
II	All Retirees of Employer under age 65 are not eligible for coverage under this policy, but they may enroll their Medicare Eligible Dependents entitled to Medicare benefits.
III	All widow or widower who is entitled to Medicare benefits whose deceased Spouse was an active Employee/Retiree of the Policyholder.

BENEFIT DEDUCTIBLES, MAXIMUMS AND COINSURANCE	
Calendar Year Policy Deductible:	None Does not reduces the Out-of-Pocket Expense Maximum
Out-of-Pocket Expense Maximum for Medicare Part A and Medicare Part B:	Unlimited Applies to Medicare Part B
Out-of-Pocket Expense Maximum applies separately to each Covered Person and each Calendar Year. When the Out-of Pocket Expense Maximum is met by a Covered Person for a benefit to which it applies, We will pay 100% of covered expenses the Covered Person Incurs on and after that date for that benefit, subject to any benefit maximums.	
Policy Coinsurance:	See the entries in the sections below for the percentages the Covered Person may be required to pay and the percentages which We pay.
Policy Copayment:	See the entries in the sections below for the Policy Copayment.
Lifetime Policy Maximum Benefit:	None
Calendar Year Policy Maximum:	None

MEDICARE PART A BENEFITS (Please be sure to read the corresponding benefit provisions in this Certificate for details on the benefits below.)			
	MEDICARE PAYS	**WE PAY**	**COVERED PERSON PAYS**
Hospital Confinement Benefit			
1st through 60th Day: *Medicare Part A Deductible* – Coverage:	All but $1,316	100% of the remaining Medicare Part A Deductible.	0% of the remaining Medicare Part A Deductible.
61st through 90th Day: *Medicare Part A Coinsurance* – Coverage:	All but a daily Medicare Coinsurance charge equal to 25% of the Medicare Part A Deductible	100% of the remaining Medicare Part A Coinsurance.	0% of the remaining Medicare Part A Coinsurance.
91st through 150th Day: *Medicare Part A Coinsurance* – Coverage (Lifetime Reserve Period):	All but a daily Coinsurance charge equal to 50% of the Medicare Part A Deductible	100% of the remaining Medicare Part A Coinsurance.	0% of the remaining Medicare Part A Coinsurance.
Extended Hospital Confinement Benefit			
For 365 Days after the Lifetime Reserve Period:	$0	100% of the charges Incurred.	0% of the the charges Incurred.
Skilled Nursing Facility Confinement Benefit			
Days 1 – 20	All Medicare Approved Amounts	$0	Amounts not paid by Medicare.
21st Through 100th Day – <u>Policy Coinsurance</u> Coverage:	All but (12.5% of Medicare Part A Deductible).	100% of the remaining Medicare Part A Skilled Nursing Facility Confinement Coinsurance.	0% of the remaining Medicare Part A Skilled Nursing Facility Confinement Coinsurance.

MEDICARE PART B BENEFITS All Policy Copayments below are per visit unless stated otherwise. (Please be sure to read the corresponding benefit provisions in this Certificate for details on the benefits below.)			
	MEDICARE PAYS	**WE PAY**	**COVERED PERSON PAYS**
Physician Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Specialist Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Outpatient Hospital Services and Ambulatory Surgical Care Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Outpatient Diagnostic and Radiology Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Outpatient Mental Health and Substance Abuse Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.

MEDICARE PART B BENEFITS All Policy Copayments below are per visit unless stated otherwise. (Please be sure to read the corresponding benefit provisions in this Certificate for details on the benefits below.)			
	MEDICARE PAYS	**WE PAY**	**COVERED PERSON PAYS**
Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Emergency Care Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Urgent Care Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Ambulance Services Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
Durable Medical Equipment and Prosthetics Benefit			
Medicare Part B *Deductible* – Coverage:	All but $183	100% of the remaining Medicare Part B Deductible.	0% of the remaining Medicare Part B Deductible.
Medicare Part B *Coinsurance* – Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the Medicare Part B Coinsurance.	0% of the Medicare Part B Coinsurance.
MEDICARE PART B EXCESS EXPENSE BENEFIT			
	$0	100%	0%

ADDITIONAL PLAN BENEFITS (Please be sure to read the corresponding benefit provisions in this Certificate for details on the benefits below.)			
	MEDICARE PAYS	**WE PAY**	**COVERED PERSON PAYS**
Foreign Travel Emergency Benefit:	$0	80% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Lifetime Foreign Travel Emergency Benefit Maximum of $50,000.	1) $250 Foreign Travel Emergency Benefit Deductible. 2) 20% Foreign Travel Emergency Benefit Coinsurance.
Preventive Care Cancer Screening Benefit:	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance.	100% of remaining covered expenses Incurred not covered by Medicare.	$0
Hospice Care Benefit:	Generally 100% of the expenses Incurred, except Coinsurance charges.	100% of remaining covered Coinsurance charges.	$0
Blood Deductible Benefit:	$0	100% of covered expenses Incurred.	$0
Hearing Services Benefit:	80% of Medicare Approved Amounts under Medicare Part B.	100% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Hearing Services Benefit Maximum of $1,000 per Calendar Year.	$25 Policy Copayment per exam. $50 Policy Copayment for two hearing aids, including fitting and evaluation.
Vision Services Benefit:	80% of Medicare Approved Amounts under Medicare Part B.	100% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Vision Services Benefit Maximum of $500 per Calendar Year.	$25 Policy Copayment per exam. $50 Policy Copayment per pair of glasses or supply of contact lenses.
Acupuncture Services Benefit:	$0	100% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Acupuncture Services Benefit Maximum of $500 per Calendar Year.	$25 Policy Copayment per visit.
Annual Physical Exam Benefit:	$0	100% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Annual Physical Benefit Maximum of $500 per Calendar Year.	$25 Policy Copayment per physical.
Chiropractic Services Benefit:	0% of Medicare Approved Amounts under Medicare Part B.	100% of remaining covered expenses Incurred, after the Covered Person's payment, up to the Chiropractic Services Benefit Maximum of $500 per Calendar Year.	$25 Policy Copayment per visit.

GENERAL DEFINITIONS

Terms used in this Certificate are defined below. Some terms specific to a benefit are defined in the respective benefit provision.

Admission means the period from and including the first day the Covered Person receives medical services as an Inpatient in a Hospital through the date the Covered Person is discharged.

Ambulance Services means ground transportation to transport to a Hospital or Skilled Nursing Facility for Medically Necessary services, when transport in any other vehicle could endanger the health of the passenger.

Ambulatory Surgical Care means surgical services provided to patients at a licensed ambulatory surgical center when:

1) the patient does not require Hospital Confinement; and
2) the stay in the ambulatory surgical center does not exceed 24 hours.

Benefit Period means the period that starts the day the Covered Person is admitted into a Hospital or Skilled Nursing Facility. The benefit period ends when the Covered Person has not received any Inpatient Hospital care or Skilled Nursing Facility care for 60 consecutive days. If the Covered Person is admitted to a Hospital or a Skilled Nursing Facility after one benefit period has ended, a new benefit period starts. The Covered Person must pay the Medicare inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Calendar Year Policy Deductible means the amount of eligible expenses the Covered Person must Incur before any benefits are paid by Us during a Calendar Year. This amount is shown in the Schedule. Expenses Incurred to satisfy the Medicare Part B Deductible and Medicare Part B Coinsurance apply to the calendar year policy deductible. Also see the definitions of Medicare Part A Deductible and Medicare Part B Deductible.

Calendar Year Policy Maximum means the most We will pay under The Policy for all benefits for any one Covered Person during any Calendar Year. It is shown in the Schedule.

Cardiac Rehabilitative Services means a customized program of exercise and education, designed to help recover from a heart attack, other forms of heart disease or surgery to treat heart disease.

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

Coinsurance means the percentage the Covered Person may be required to pay of certain expenses after meeting the applicable Deductible. Also see the definitions of Policy Coinsurance, Medicare Part A Coinsurance, Medicare Part B Coinsurance and Skilled Nursing Facility Confinement Coinsurance.

Confined or **Confinement** means being an Inpatient in:

1) a Hospital; or
2) a Skilled Nursing Facility with respect to Skilled Nursing Facility Confinement coverage;

due to Injury or Sickness.

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

Copayment means the amount the Covered Person may be required to pay as his or her share of the cost of medical services, treatments or supplies under insurance coverage. Also see the definition of Policy Copayment.

Covered Person means You and any Dependents insured under this Certificate.

Deductible means the amount the Covered Person must pay for medical services, treatment or supplies before his or her insurance starts to pay under Medicare or other coverages. Also see the definitions of Calendar Year Policy Deductible, Additional Plan Benefits Deductible, Medicare Part A Deductible and Medicare Part B Deductible.

Dependent or **Dependents** means Your Spouse.

A dependent must be a citizen or legal resident of the United States or one of its territories or protectorates.

Durable Medical Equipment means certain medical equipment that is ordered by the Covered Person's treating Physician for medical reasons. These include, but are not limited to: walkers, wheelchairs, crutches, IV infusion pumps, oxygen equipment, nebulizers, or hospital beds.

Emergency Care means, with respect to an emergency condition:

1) a medical screening examination, as required under section 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, which is within the capabilities of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate the emergency medical condition; and
2) within the capabilities of the staff and facilities available at the Hospital, further medical examination and treatment, as are required under section 1867 of the Social Security Act, 42 U.S.C. Section 1395dd, to stabilize the Covered Person;

required due to:

1) a medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
    a) placing the health of the person afflicted with the condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    b) in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
    c) serious impairment to such person's bodily functions;
    d) serious dysfunction of any bodily organ or part of such person; or
    e) serious disfigurement of such person; or
2) with respect to a pregnant woman who is having contractions:
    a) inadequate time to effect a safe transfer to another Hospital before delivery, or
    b) a transfer posing a threat to the health or safety of the woman or the unborn child.

In this definition, "to stabilize" means to provide such medical treatment of the condition as may be necessary to:

1) assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the Covered Person from a facility; or
2) deliver a newborn child (including the placenta).

Employer means the Policyholder.

Family Member means the Covered Person's parent, spouse, children, siblings, grandparent, aunt, uncle, first cousin, nephew or niece. This includes those relations listed acquired through an adoption, in-laws and step-relatives.

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

Hospital means a short-term, acute, general hospital, which:

1) is primarily engaged in providing by, or under the continuous supervision of Physicians, to Inpatients diagnostic services and therapeutic services for diagnosis, treatment and care;
2) has organized departments of medicine and major surgery;
3) has a requirement that every patient must be under the care of a Physician or dentist;
4) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
5) if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of United States Public Law 89-97 (42 USCA 1395x(k));
6) is duly licensed by the agency responsible for licensing such hospitals; and
7) is not, other than incidentally a place:
    a) of rest;
    b) primarily for the treatment of tuberculosis;
    c) for the aged;
    d) for drug addicts or alcoholics; or
    e) for convalescent, custodial, educational, or rehabilitory care.

Incur or **Incurred** means that, with respect to any expense, the Covered Person receives, or has received, the treatment, service or supply that gives rise to the expense. A Covered Person is considered to incur an expense on the date the treatment, service or supply is received.

Inpatient means a patient in:

1) a Hospital;
2) a Skilled Nursing Facility; or
3) Hospice Care;

being charged room and board.

Injury means bodily injury:

1) resulting directly from accident;
2) resulting independently of all other causes; and
3) occurring while the Covered Person is insured under The Policy.

Loss resulting from:

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

is not considered as resulting from Injury.

Lifetime Policy Maximum Benefit means the most We will pay under The Policy for all benefits for any one Covered Person during his or her lifetime. This amount is shown in the Schedule.

Lifetime Reserve Period means the additional days that Medicare will pay for when the Covered Person is Hospital Confined for more than 90 days. The Covered Person has a total of 60 reserve days that can be used during his or her lifetime.

Medically Necessary means:

1) recommended by the treating Physician acting within the scope of his or her license;
2) consistent with currently accepted medical practice; and
3) generally considered to be appropriate for a given medical condition.

Medicare means Title XVIII of the Social Security Act of 1965, as amended.

Medicare Approved Amount means the amount a Physician or supplier that accepts Medicare Assignment can be paid. It includes what Medicare pays and any Deductible, Coinsurance or Copayment that the Covered Person or his or her insurance pays. It may be less than the actual amount a Physician or other provider of medical services charges.

Medicare Approved Skilled Nursing Facility Confinement means Confinement in a Skilled Nursing Facility that provides skilled, Medically Necessary care:

1) at a level that satisfies Medicare standards;
2) starting within 30 days of discharge from a Hospital Confinement of at least 3 consecutive days; and
3) that is recommended by the treating Physician.

Medicare Assignment means an agreement by a Physician or other provider of medical services to accept Medicare Approved Amounts as full payment for Medicare covered services.

Medicare Part A Coinsurance or **Medicare Part B Coinsurance** mean(s) the percentage of Medicare approved expenses the Covered Person may be required to pay after meeting the Medicare Part A Deductible or the Medicare Part B Deductible, respectively. The percentages and Deductibles are shown in the Schedule. Also see the definitions of Coinsurance and Policy Coinsurance.

Medicare Part A Deductible means the amount the Covered Person is required to pay each Benefit Period under Medicare Part A for the expenses Incurred before Medicare will pay any Medicare Part A benefits. This amount is shown in the Schedule. Also see the definitions of Calendar Year Policy Deductible.

Medicare Part A Skilled Nursing Facility Confinement Coinsurance means the amount the Covered Person is required to pay for a Skilled Nursing Facility Confinement starting with the 21st day of Confinement. This amount is shown in the Schedule. Also see the definitions of Coinsurance and Policy Coinsurance.

Medicare Part B Deductible means the amount the Covered Person is required to pay under Medicare Part B for the expenses Incurred each Calendar Year before Medicare will pay any Medicare Part B benefits. This amount is shown in the Schedule. Also see the definitions of Calendar Year Policy Deductible.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A mental illness may be caused by biological factors or result in physical symptoms or manifestations.

Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Intellectual Disability (Intellectual Developmental Disorder);
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Out-of-Pocket Expense means the amount the Covered Person pays for expenses covered and Incurred under The Policy's benefit provisions. Out-of-Pocket Expenses do not include:

1) expenses that are excluded or limited under The Policy; or
2) amounts in excess of the Medicare Approved Amount.

Outpatient means a person who receives medical treatment, services or supplies at a Hospital or licensed ambulatory care facility for which there is no charge for room and board.

Outpatient Diagnostic Services means procedures performed to diagnose Injury or Sickness. These include, but are not limited to:

1) radiography;
2) ultrasound;
3) computed tomography;
4) nuclear medicine;
5) positron emission tomography; and
6) magnetic resonance imaging and laboratory tests.

Outpatient Hospital Services means services received in the Outpatient department of a Hospital for diagnosis or treatment. Services include, but are not limited to, observation services and Outpatient surgery received in:

1) an emergency department; or
2) Outpatient clinic.

Unless a Physician has written an order to admit the Covered Person as an Inpatient to the Hospital, the Covered Person is an Outpatient and must pay the cost-sharing amounts for Outpatient Hospital services, even if the Covered Person stays in the Hospital overnight.

Outpatient Mental Health Services means services to evaluate and treat mental health conditions that affect mood, thinking and behavior including, but not limited to:

1) depression;
2) anxiety disorders;
3) schizophrenia;
4) eating disorders; and
5) addictive behaviors.

Outpatient Rehabilitative Services means treatments designed to facilitate the process of recovery from Injury or Sickness to as normal a condition as possible. Treatments must be performed in an Outpatient facility. Services include, but are not limited to:

1) physical therapy;
2) occupational therapy; and
3) speech language therapy.

Outpatient Substance Abuse Services means services that provide a detoxification regimen of medically directed evaluation, care and treatment for psychoactive substance abuse in a medically managed setting. These services must be provided in an Outpatient facility.

Physician means a person who is:

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

Physician Services means professional services performed by a Physician including, but not limited to:
1) diagnosis;
2) therapy;
3) surgery;
4) consultation; and
5) care plan oversight.

Policy Coinsurance means the percentage, shown in the Schedule, that the Covered Person may be required to pay after meeting the Calendar Year Policy Deductible and any Additional Plan Benefits Deductible or Foreign Travel Emergency Benefit Deductible, but before satisfying any applicable Out-of-Pocket Expense Maximum. Also see the definitions of Coinsurance, Medicare Part A Coinsurance and Medicare Part B Coinsurance.

Policy Copayment means the amount, shown in the Schedule; the Covered Person may be required to pay under The Policy as his or her share of the cost of medical services, treatments or supplies.

Primary Insured means the person to whom this Certificate is issued.

Prior Policy means the health insurance carried or sponsored by the Policyholder or by an employer acquired by the Policyholder on the day before the Policy Effective Date. This includes only coverage transferred to Us.

Prosthetics means devices that replace all or part of a body part or function. This includes, but is not limited to:
1) colostomy bags and supplies directly related to colostomy care;
2) pacemakers;
3) braces used for physical support;
4) prosthetic shoes;
5) artificial limbs;
6) breast prostheses (including a surgical brassiere after a mastectomy);
7) certain supplies related to prosthetic devices; and
8) repair and/or replacement of prosthetic devices.

This does not include dental devices.

Radiology Services means the use of radiography, ultrasound, computed tomography, nuclear medicine, positron emission tomography and magnetic resonance imaging to diagnose and treat Injury or Sickness.

Request means a written request by the Covered Person made on the forms We furnish for making the request.

Retiree means a former employee of the Policyholder who has attained the Policyholder's Normal Retirement Age.

Policyholder's Normal Retirement Age, as used above, means the age determined by the Policyholder in its established guidelines.

Schedule means the schedule of benefits for this Certificate.

Sickness means illness, disease or disorder of the body.

Skilled Nursing Facility means an institution that:
1) operates pursuant to law;
2) in addition to room and board accommodations, is primarily engaged in providing skilled nursing care under the supervision of a Physician;
3) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate nurse (R.N.); and
4) maintains a daily medical record of each patient.

Skilled Nursing Facility does not mean any institution or part thereof that is used mainly as a home or place for:

1) the aged, or for rest, custodial or educational care;
2) alcoholism and drug addiction;
3) the treatment of Mental Illness.

Skilled Nursing Facility Expenses means Medicare Part A eligible expenses for services provided and billed by a Skilled Nursing Facility.

Specialist means a Physician who treats only certain:
1) parts of the body;
2) health problems, including, but not limited to, heart problems; or
3) age groups.

Specialist Services means surgery services and other services furnished by a Specialist including, but not limited to:
1) consultation;
2) diagnosis;
3) treatment; and
4) second opinion prior to surgery.

Spouse means any individual who is recognized as Your spouse under applicable state law.

Spouse does not include any person who is insured as a Retiree.

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

Urgent Care means non-emergency services to treat Sickness or Injury that requires immediate medical care.

Usual and Customary Charge means the prevailing charge made by most providers of a given service in the geographic area where the service is received. In no event will the Usual and Customary Charge exceed the actual amount charged.

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

You or Your means the Primary Insured.

ELIGIBILITY AND EFFECTIVE DATES

Primary Insured's Eligibility for Coverage: You will become eligible for coverage on the latest of:
1) the Policy Effective Date; or
2) the date You become a member of an Eligible Class for Coverage.

Dependents' Eligibility for Coverage: Your Dependent(s) will become eligible for coverage on the later of:
1) the date You become insured for Retiree coverage; or
2) the date You acquire Your first Dependent.

You may not cover Your Dependent if he or she is covered as a Retiree under The Policy. No person can be insured as a Dependent of more than one Retiree under The Policy.

Eligibility Restriction: In no event will a person be eligible for coverage under The Policy if he or she:
1) is engaged in active employment or is the Dependent of a person engaged in active employment, and is eligible to be covered by an employer's health plan which is primary payor to Medicare;
2) is covered by Medicaid for medical coverage;
3) is covered by a Medicare Advantage plan (Medicare Part C);
4) has other coverage in force that supplements Medicare or which provides coverage for his or her hospital or medical expense; or
5) is not eligible to be covered by Medicare.

Enrollment: For Contributory Coverage, the Policyholder will automatically enroll You and Your Dependents for coverage.

To enroll for Contributory Coverage, You may be requested to:

1) complete and sign a group insurance enrollment form, which is satisfactory to Us, for Your and Your Dependents' coverage within 31 days of the date You are eligible for coverage; and
2) deliver it to the Policyholder.

Your Coverage Effective Date: If You attained age 65 while covered under the Prior Policy, Your coverage will start on the date stated in the Prior Policy's provision transferring coverage to another insurer, subject to the Deferred Effective Date and Dependents' Deferred Effective Date provisions. Otherwise, Your coverage will start as stated below.

Contributory Coverage will start on the date You become eligible, subject to the Deferred Effective Date provision.

Contributory Coverage will start on the latest to occur of:

1) the date You become eligible, if You enroll on or before that date; or
2) the date You enroll, if You do so within 31 days from the date You are eligible;

subject to the Deferred Effective Date provision.

Deferred Effective Date: If on the Policy Effective Date, You are Confined in a Hospital or Skilled Nursing Facility, Your coverage will start on the date You are discharged.

Dependents' Effective Date: Contributory Coverage will start on the date You become eligible for Dependent coverage, subject to the Dependents' Deferred Effective Date provisions.

Contributory Coverage will start, subject to the Dependents' Deferred Effective Date provision, on the latest to occur of:

1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Dependents' Deferred Effective Date: If on the Policy Effective Date, Your Dependent is Confined in a Hospital or Skilled Nursing Facility, Your Dependents' coverage will start on the date he or she is discharged.

Changes in Coverage Due to Change in The Policy: Any increase or decrease in coverage because of a change in The Policy by the Policyholder will become effective on the date of the change.

TERMINATION

Termination of Your Coverage: Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or The Policy no longer covers Your class;
3) the date the required premium is due but not paid, subject to the Individual Grace Period Policyholder Grace Period; or
4) the date You request We terminate Your coverage;

unless continued under the Continuation Provisions.

In addition, if You are eligible for coverage under The Policy because You are the widow or widower of a retired employee of the Policyholder, Your coverage will end on the first day of the month on or next following the date You remarry.

Individual Grace Period: You will be allowed an Individual Grace Period of 31 days from the Premium Due Date for payment of each premium due after the initial premium. Your insurance will be continued during the Individual Grace Period. If the Covered Person has a covered loss during the Individual Grace Period, the Covered Person will be liable to Us for payment of any premium accruing during the period We continued coverage in force under the provision.

The Individual Grace Period will not continue coverage after any date on which coverage would end, as stated in Termination of Your Coverage.

Termination of Your Dependents' Coverage: Coverage for Your Dependent(s) will end on the earliest of the following:

1) the date Your coverage ends;
2) the date the required premium is due but not paid, subject to the Individual Grace Period the Policyholder Grace Period;

3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Policyholder terminate Dependent coverage;
5) the date You request We terminate Dependent coverage; or
6) the date You and Your Spouse are no longer married or legally terminate Your relationship;

unless continued under the Continuation Provision.

CONTINUATION PROVISIONS

Surviving Dependent Continuation: If You die while insured under The Policy, coverage for Your Dependents that is in force on the date of Your death may be continued, until the earliest of:

1) the date the coverage would otherwise have ended under Termination of Your Dependents' Coverage;
2) the date Your Spouse remarries; or
3) the date Your Spouse obtains coverage under another group plan.

We must receive Your Dependents' Request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the Primary Insured.

BENEFIT PAYMENTS

We will pay benefits under The Policy only when the following requirements are met:

1) the expense Incurred:
   a) is a Medicare eligible expense, except as may be stated for the Additional Plan Benefits;
   b) is for Medically Necessary services, treatments or supplies; and
   c) does not exceed the Usual and Customary Charge;
2) if the Covered Person is Confined in a Hospital, the Confinement is a Medicare approved Confinement;
3) We have verified that the Covered Person's insurance coverage is in force on the date the expense is Incurred;
4) the Covered Person has met any Deductibles under The Policy that apply;
5) the Covered Person has not exhausted any applicable benefit maximum;
6) the Covered Person has not exhausted the Lifetime Policy Maximum Benefit; and
7) for any Calendar Year, the Covered Person has not exhausted the Calendar Year Policy Maximum.

The Schedule shows the applicable Copayments, Deductibles and maximums.

The Out-of-Pocket Expense Maximums apply as stated in the Schedule. Once satisfied, We pay benefits as stated in the Schedule.

For an expense to be covered under a benefit provision, the expense must be Incurred while the Covered Person is insured for that benefit.

Changes to Medicare: Benefits are adjusted annually or upon the effective date established by Medicare to reflect changes in the Medicare program. These changes may cause increases or decreases in benefit amounts payable under The Policy.

MEDICARE PART A BENEFITS

Hospital Confinement Benefit

When a Covered Person is Confined in a Hospital, We will pay the benefits stated below. The Confinement must be a Medicare approved Confinement. The Covered Person must Incur expenses for the Confinement while insured under this benefit.

1st Through 60th Day of Hospital Confinement; *Medicare Part A Deductible* Coverage: For the first 60 days of a Medicare approved Hospital Confinement during a Benefit Period, Medicare pays all Inpatient Hospital expenses Incurred, except for the Medicare Part A Deductible.

Under this benefit:

1) the Covered Person pays his or her percentage of the remaining Medicare Part A Deductible; and
2) We pay Our percentage of the remaining Medicare Part A Deductible;

shown in the Schedule.

61st Through 90th Day of Hospital Confinement; *Medicare Part A Coinsurance* Coverage: From the 61st through 90th day of a Medicare approved Hospital Confinement during a Benefit Period, Medicare pays all Inpatient Hospital expenses Incurred, except a daily Coinsurance charge equal to the percentage of the Medicare Part A Deductible shown in the Schedule.

Under this benefit:

1) the Covered Person pays his or her percentage of the remaining Medicare Part A Coinsurance; and
2) We pay Our percentage of the remaining Medicare Part A Coinsurance;

shown in the Schedule.

91st Through 150th Day of Hospital Confinement; *Medicare Part A Coinsurance* Coverage: Regular Medicare Hospital benefits end on the 90th day of Hospital Confinement during a Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If he or she uses the days, Medicare pays all Inpatient Hospital expenses Incurred during the Lifetime Reserve Period except a daily Coinsurance charge equal to the percentage of the Medicare Part A Deductible shown in the Schedule.

Under this benefit:

1) the Covered Person pays his or her percentage of the remaining Medicare Part A Coinsurance; and
2) We pay Our percentage of the remaining Medicare Part A Coinsurance;

shown in the Schedule.

Extended Hospital Confinement Benefit

Starting once Medicare's benefits are exhausted for Hospital Confinement during a Benefit Period:

1) the Covered Person pays his or her percentage; and
2) We pay Our percentage;

shown in the Schedule of the charges Incurred for Inpatient Hospital expenses for each additional day of Confinement during that Benefit Period.

This benefit is payable for the number of days of Hospital Confinement per Lifetime, shown in the Schedule, after the Lifetime Reserve Period.

Skilled Nursing Facility Confinement Benefit

When a Covered Person is Confined in a Skilled Nursing Facility, We will pay the benefit stated below. The Confinement must be a Medicare Approved Skilled Nursing Facility Confinement.

1st Through 20th Day of Skilled Nursing Facility Confinement: For the first 20 Days of a Medicare Approved Skilled Nursing Facility Confinement during a Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses. The Policy provides no coverage under this benefit for those 20 days.

21st Through 100th Day of Skilled Nursing Facility Confinement: From the 21st through 100th day of a Medicare Approved Skilled Nursing Facility Confinement during a Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses except a daily Coinsurance charge equal to the percentage of the Medicare Part A Deductible shown in the Schedule.

Under this benefit:

1) the Covered Person pays his or her percentage of the remaining Medicare Part A Skilled Nursing Facility Coinsurance; and
2) We pay Our percentage of the remaining Medicare Part A Skilled Nursing Facility Confinement Coinsurance;

shown in the Schedule. We pay the percentage of the remaining Medicare Part A Skilled Nursing Facility Coinsurance charges the Covered Person Incurs for those days, shown in the Schedule.

MEDICARE PART B BENEFITS

The coverages for Medicare Part B Benefits are described below. The Medicare Part B Benefits provided under this Certificate are shown in the Schedule of Benefits.

Medicare Part B *Deductible* Coverage: Under this benefit:

1) the Covered Person pays his or her percentage of the remaining Medicare Part B Deductible; and
2) We pay Our percentage of the remaining Medicare Part B Deductible;

shown in the Schedule.

Option 1 - Medicare Part B *Coinsurance* Coverage: During a Calendar Year, after the Medicare Part B Deductible is met, Medicare generally pays the percentage of Medicare Part B eligible expenses shown in the Schedule. The Covered Person is responsible for the balance.

Under this benefit:

1) the Covered Person pays his or her percentage; and
2) We pay Our percentage;

of the Medicare Part B Coinsurance shown in the Schedule.

MEDICARE PART B EXCESS EXPENSE BENEFIT

Excess Expense means the difference between:

1) the amount billed for the Medicare Part B services plus the Limiting Charge; and
2) the Medicare Approved Amount.

Under this benefit, during any Calendar Year the Medicare Part B Deductible is met, the Covered Person will pay his or her percentage and We will pay Our percentage, shown in the Schedule, of the difference between 1) and 2). However, the amount of Our payment will not exceed the amount of any limit determined by state law or the Limiting Charge established by Medicare.

Limiting Charge means the highest amount the Covered Person can be charged for a covered service by Physicians and other health care providers who do not accept Medicare Assignment. The limit is 15% over Medicare's Approved Amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

We will not pay this benefit if:

1) the provider of the medical care accepts Medicare Assignment; or
2) the service or supply is not covered by Medicare Part B.

ADDITIONAL PLAN BENEFITS

Foreign Travel Emergency Benefit

Under this benefit the Covered Person pays:

1) the Foreign Travel Emergency Benefit Deductible; and
2) the Foreign Travel Emergency Benefit Coinsurance percentage of the expenses for Foreign Travel Emergency Medical Treatment;

shown in the Schedule. Then We pay the remaining percentage of covered expenses up to the Lifetime Foreign Travel Emergency Benefit Maximum shown in the Schedule. For benefits to be payable, the Covered Person must Incur the first expense within 60 days of travel Outside of the United States.

This benefit does not cover Foreign Travel Emergency Medical Treatment if the Covered Person:

1) leaves the United States primarily to seek Foreign Travel Emergency Medical Treatment for an Injury or a Sickness;
2) has no legal obligation to pay for the treatment; or
3) receives the treatment during a Calendar Year in which the Covered Person travels or resides Outside of the United States for 6 consecutive months or longer.

If Medicare approves Foreign Travel Emergency Medical Treatment:

1) no benefits are payable under this provision for the treatment; and
2) other benefits under The Policy may provide coverage for the treatment.

If Medicare does not approve Foreign Travel Emergency Medical Treatment:

1) We will pay benefits for the treatment as stated in this provision; and
2) no benefits are payable for the treatment under any other benefit provision.

Foreign Travel Emergency Medical Treatment means any Medically Necessary Confinement, service or supply needed immediately due to Injury or Sickness of sudden and unexpected onset while the Covered Person is Outside of the United States, provided that the medical treatment, if received in the United States, would:

1) be considered reimbursable treatment under Medicare;
2) be considered in general use and of demonstrated value in the diagnosis and treatment of Injury or Sickness by Physicians within the United States;
3) be provided by a Physician; and
4) not be considered in a research or experimental stage by Physicians within the United States.

Foreign Travel Emergency Medical Treatment does not include incidental services including, but not limited to:

1) airfare;
2) travel fees;
3) lodging; or
4) meals;

for the Covered Person.

Outside of the United States means outside the territorial limits of:

1) the 50 United States and the District of Columbia; and
2) Puerto Rico, the Virgin Islands, Guam and American Samoa.

Preventive Care Cancer Screening Benefit

We will pay the charges Incurred by the Covered Person for any of the following tests when not covered by Medicare:

1) one ovarian cancer surveillance test each Calendar Year ordered by a Physician;
2) one colon cancer screening each Calendar Year when ordered by a Physician;
3) annual cervical cytology screening for cervical cancer and its precursor states for women age 18 and older, which must include:
    a) an annual pelvic examination;
    b) collection and preparation of a Pap smear; and
    c) laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear;
4) upon the recommendation of a Physician, a mammogram at any age for Covered Persons:
    a) having a prior history of breast cancer; or
    b) who have a first degree relative with a prior history of breast cancer;
5) a single baseline mammogram for Covered Persons age 35 through 39, inclusive;
6) an annual mammogram for Covered Persons age 40 and older;
7) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and
8) an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men:
    a) age 50 and over who are asymptomatic; and
    b) for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

Hospice Care Benefit

Hospice Care means Medicare approved medical and support services needed to manage the symptoms and relieve the pain of a terminal illness provided through a Medicare approved Hospice Care program. Hospice Care includes, but is not limited to:

1) nursing care, therapies, medical supplies and appliances;
2) short-term Inpatient respite care; and
3) Physician, home health aide and counseling services.

Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except Coinsurance charges for Inpatient respite care, drugs and biologicals.

If the Covered Person elects to receive Hospice Care, We will pay the Medicare Part A and Medicare Part B Coinsurance charges that the Covered Person Incurs.

The Hospice Care must be:
1) approved by Medicare; and
2) received while insured under this benefit.

If payment under this benefit is due for an expense, no other benefits of The Policy will be provided for that expense.

Blood Deductible Benefit

Medicare does not cover the first 3 pints of blood received each Calendar Year.

We will pay the expenses the Covered Person Incurs for these first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations.

Hearing Services Benefit

Hearing Services means:
1) diagnostic hearing and balance evaluations performed by a Physician or certified audiologist;
2) routine hearing and balance exams;
3) hearing aids; and
4) tests for fitting hearing aids.

Medicare does not cover supplemental routine hearing exams and hearing aids. Medicare pays the percentage shown in the Schedule of Medicare Approved Amounts for diagnostic hearing exams provided by a Physician.

Under this benefit, the Covered Person pays the Policy Copayment, shown in the Schedule, for the following Hearing Services:
1) one routine hearing and balance exam every 12 months;
2) two hearing aids every 3 years; and
3) one hearing aid fitting evaluation every 3 years.

Then, We pay the percentage of the remaining covered expenses Incurred for these Hearing Services up to the Hearing Services Benefit Maximum shown in the Schedule.

If only one hearing aid is purchased, the full Policy Copayment shown in the Schedule must be paid. However, if a second hearing aid is purchased within the period stated above in 2), the Covered Person will not be charged an additional Policy Copayment for that hearing aid, including fitting and evaluation.

Vision Services Benefit

Vision Services means:
1) diagnosis and treatment of Sicknesses and Injuries of the eye, including, but not limited to, treatment for age-related macular degeneration;
2) routine eye exams (eye refractions) for eyeglasses or contact lenses;
3) glaucoma screening; and
4) prescription eyeglasses or contact lenses.

Medicare does not cover supplemental routine eye exams and glasses. Medicare pays the percentage shown in the Schedule of Medicare Approved Amounts for:
1) diagnosis and treatment of Sicknesses and Injuries of the eye;
2) one pair of eyeglasses or contact lenses after cataract surgery; and
3) annual glaucoma screenings for persons at risk.

Under this benefit, the Covered Person will pay the Policy Copayment, shown in the Schedule, for the following Vision Services:

1) one supplemental routine eye exam every 12 months; and
2) one pair of glasses every 12 months or 12 month supply of contact lenses;

for the period shown in the Schedule. Then, We pay the percentage of the remaining covered expenses Incurred for these Vision Services up to the Vision Services Benefit Maximum shown in the Schedule.

Acupuncture Services Benefit

Acupuncture Services means services performed by a licensed acupuncturist to treat pain, involving the insertion of needles through skin at strategic points on the body.

Medicare does not cover Acupuncture Services.

The Covered Person pays the Policy Copayment, shown in the Schedule, for Acupuncture Services. Then, We pay the percentage of the covered expenses Incurred for Acupuncture Services up to the Acupuncture Services Benefit Maximum shown in the Schedule.

Annual Physical Exam Benefit

Medicare does not cover annual physical exams.

The Covered Person pays the Policy Copayment shown in the Schedule. Then, We pay the remaining expenses Incurred by the Covered Person for one physical exam performed by a Physician per Calendar Year up to the Annual Physical Benefit Maximum shown in the Schedule. The exam may include one or more of the following:

1) review of the Covered Person's medical history;
2) check of the Covered Person's memory and mental quickness;
3) check of the Covered Person's blood pressure, heart rate, respiration rate and temperature;
4) check of the Covered Person's general appearance;
5) heart, lung, head and neck, abdominal, neurological, dermatological, hernia and extremities exams;
6) exam of a male Covered Person's sexual organs and a prostate exam;
7) a breast exam and pelvic exam for female Covered Persons;
8) laboratory tests for a complete blood count, chemistry panel, urinalysis and lipid panel;
9) discussion of risk factor reductions; and
10) other services performed as part of an annual exam which are not covered by Medicare or under another benefit provision of The Policy.

Any additional services provided during the exam are not covered under this benefit.

Chiropractic Services Benefit

Chiropractic Services means:

1) services performed by a licensed chiropractor to correct structural alignment and improve the body's physical function by applying controlled sudden force to a spinal joint; or
2) manual manipulation of the spine to correct subluxation.

Medicare only covers spinal manipulations.

The Covered Person pays the Policy Copayment for Chiropractic Services shown in the Schedule. Then, We pay the percentage of the expenses Incurred for Chiropractic Services not covered by Medicare up to the Chiropractic Services Benefit Maximum shown in the Schedule.

PRE-EXISTING CONDITIONS LIMITATION

Conditions Prior to Effective Date of Coverage: We will not pay a benefit under The Policy for any expenses Incurred:

1) during the first 1 year of the Covered Person's coverage; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 6 consecutive months ending on or after the Covered Person's effective date of coverage.

Conditions Prior to Effective Date of Increase in Coverage: We will not pay an increased benefit under The Policy for any expenses Incurred:

1) during the first 1 year following the effective date of a change in the Covered Person's coverage that increases the Covered Person's benefits; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 6 consecutive months ending on or after the Covered Person's effective date of benefit increase.

Change from a Prior Policy: If the Covered Person's coverage under The Policy is transferring uninterrupted from coverage under a Prior Policy, then We will credit, toward satisfaction of this Pre-existing Condition Limitation provision, the period that the Covered Person was continuously covered by that policy immediately before the transfer. Any expenses Incurred which are payable under a provision of that policy will not be payable under The Policy.

Replacement Coverage: If the Covered Person:

1) purchased coverage under The Policy to replace coverage under another retiree group or individual health insurance policy; and
2) provides proof of coverage under the replaced policy;

then We will credit, toward satisfaction of this Pre-existing Condition Limitation provision, the period that the Covered Person was continuously covered by the replaced policy immediately before the replacement.

However, if benefits under The Policy are greater than those provided by the replaced policy, this Pre-existing Condition Limitation will apply only to the increase in benefits.

Pre-existing Condition means any Injury or Sickness for which medical care is received by the Covered Person:

1) within the 6 consecutive months prior to the date the Covered Person's insurance starts; or
2) within the 6 consecutive months prior to the effective date of the Covered Person's increase in coverage.

Medical care is received when:

1) a Physician is consulted or provides medical advice; or
2) treatment is recommended or prescribed by, or received from, a Physician.

Treatment includes, but is not limited to:

1) medical examinations, tests, attendance or observations;
2) medical services, supplies or equipment, including their prescription or use; and
3) prescribed drugs or medicines, including their prescription or use.

All manifestations, symptoms, or findings which result from:

1) the same or related Injury or Sickness; or
2) any aggravations of the same or related Injury or Sickness;

are considered to be the same Injury or Sickness for the purpose of determining a Pre-existing Condition.

This Pre-existing Condition Limitation does not apply to any increase in coverage due to a change in Medicare benefits.

GENERAL LIMITATIONS AND EXCLUSIONS

Limitation If Not Enrolled in Medicare Part A and Part B: If the Covered Person has not enrolled in both Medicare Part A and Part B, We will pay the benefits under The Policy as if the Covered Person had enrolled in both parts of Medicare.

Medicare Part A and Medicare Part B Services: The portion of an expense that is more than Medicare considers reasonable is:

1) not a Medicare Part A or Medicare Part B eligible expense;
2) not covered by Medicare; and
3) not covered under The Policy.

Policy Exclusions: The Policy does not cover any Sickness or Injury arising out of:
1) war or act of war, whether declared or undeclared;
2) the Covered Person's participation in a felony; or
3) cosmetic surgery, except that cosmetic surgery does not include:
    a) reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; and
    b) reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.

Coverage Limitations: The Policy does not cover:
1) any expense that is:
    a) not a Medicare eligible expense, unless stated otherwise;
    b) beyond the limits imposed by Medicare for the expense;
    c) excluded by name or specific description by Medicare, except as specifically provided under The Policy; or
    d) Incurred for treatment when received from a provider who does not accept Medicare;
2) any expense if the Covered Person has entered into a private contract with a Physician;
3) any portion of a covered expense to the extent paid or payable by Medicare;
4) treatment not provided in accordance with general accepted professional medical standards;
5) any benefits payable under one benefit provision of The Policy to the extent payable under another benefit of The Policy;
6) covered expenses Incurred after coverage terminates;
7) expenses Incurred before coverage starts;
8) any expense that exceeds the Usual and Customary Charge;
9) telephone-medicine, e-mail-medicine, internet connection-medicine and telemedicine;
10) orthognathic surgery;
11) surrogate parenting;
12) services and supplies paid for through a legal action or settlement;
13) any expense in connection with an Injury or Sickness for which benefits are provided under workers' compensation, occupational disease, employers' liability or similar law; or
14) unless otherwise covered in The Policy, reports, evaluations, physical examinations, or Hospital Confinement not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.

Certain services that are excluded according to this provision may, at Our discretion, be covered under The Policy, if the services are required as a part of an authorized, monitored care plan.

GENERAL PROVISIONS

Statements: In the absence of fraud, all statements made by a Covered Person will be considered representations and not warranties.

Time Limit on Certain Defenses: After a Covered Person has been insured under The Policy for 2 years during his or her lifetime, no statement made by him or her, except an intentionally fraudulent misstatement, will be used to reduce or deny a claim beginning after the 2 year period. To be used, the statement must:
1) be in writing;
2) be signed by the Covered Person who made it; and
3) a copy must be given to him or her.

If the Covered Person is not of the age of majority, then the statement must be signed by the Primary Insured.

Legal Actions: No legal action may be taken against Us:
1) until 60 days after proof of loss has been given; or
2) more than 2 years after the time proof of loss is required to be given under The Policy.

Misstatement of Age: If the age of any Covered Person has been misstated:

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

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

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

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

CLAIM PROVISIONS

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

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

Proof of Loss: The claimant must send written proof of loss to Us. This proof must be provided within 120 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Time of Payment of Claims: Benefits payable under this Certificate will be paid within 60 days after Our receipt of due written Proof of Loss.

Payment of Claims: Unless benefit payments are assigned as stated below, all benefits are payable to You. Any payments owed at Your death may be paid to Your estate in a lump sum.

Assignment of Benefit Payments: You may assign the Covered Person's benefit payments to the institution or person rendering service by giving Us a written release. You may not assign any coverage or rights and duties under this Certificate in any other way or to any other person.

Claim Denial: If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written notification will:

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

Claim Appeal: On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so he or she must submit a Request within 180 days of receipt of the claim denial. The claimant may:

1) request copies of all documents, records, and other information relevant to the claim; and
2) 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 any amount that We determine to be an overpayment. In the absence of an assignment, as described in Assignment of Benefit Payments above, You have the obligation to reimburse Us any such amount within 90 days after the date of the overpayment.

If You do not reimburse Us in a timely manner, We have the right to:

1) recover such overpayments from:
    a) You; and
    b) 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.

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

1) examine the Covered Person when and as often as We may reasonably require during the pendency of a claim under The Policy; and
2) make an autopsy in case of death where it is not forbidden by law.

State Mandates and Exceptions Provisions Rider

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

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

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

This rider amends Your Certificate, as stated below, to comply with the laws and requirements of the state in which The Policy is issued. Only those references to benefits, provisions or terms actually included in Your Certificate will affect Your coverage. In addition, any reference made to Dependent coverage will only apply if Dependent coverage is provided in Your Certificate.

The following provisions are added to Your certificate:

Inpatient Chemical Abuse and Chemical Dependence Diagnosis and Treatment Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the diagnosis and treatment of Chemical Abuse and Chemical Dependence as follows:

1) with respect to benefits for detoxification due to Chemical Dependence, Inpatient benefits in a Hospital or a detoxification facility for 7 days of active treatment in any Calendar Year; and
2) with respect to benefits for rehabilitation services, 30 days of Inpatient care in any Calendar Year.

Diagnosis and treatment must be received:

1) in New York state, in facilities which are certified by the Office of Alcoholism and Substance Abuse Services; and
2) in other states, in facilities accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or Chemical Dependence treatment programs.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A Benefits.

Chemical Abuse means alcohol and substance abuse.

Chemical Dependence means alcoholism and substance dependence.

Autism Diagnosis and Treatment Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for:

1) screening for Autism Spectrum Disorder;
2) Diagnosis of Autism Spectrum Disorder;
3) Treatment of Autism Spectrum Disorder; and

4) Applied Behavior Analysis, subject to a maximum benefit of 680 hours of treatment per Calendar Year per Covered Person.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

Limitation: The Policy does not cover any treatment provided to the Covered Person pursuant to an individualized education plan under Article 89 of the Education Law of the state of New York. However, services provided pursuant to an individualized:

1) family service plan under Section 2545 of the Public Health Law of the state of New York;
2) education plan under Article 89 of the Education Law of the state of New York; or
3) service plan pursuant to regulations of the Office for Persons with Developmental Disabilities;

do not affect coverage under The Policy for services provided on a supplemental basis outside of an educational setting if they are prescribed by a Physician or licensed psychologist.

When used in this provision, the following terms have the meanings as shown below:

Autism Spectrum Disorder means any pervasive developmental disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including:

1) autistic disorder;
2) Asperger's disorder;
3) Rett's disorder;
4) childhood disintegrative disorder; and
5) pervasive developmental disorder not otherwise specified (PDD-NOS).

Applied Behavior Analysis means the:

1) design;
2) implementation; and
3) evaluation of environmental modifications;

using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of:

1) direct observation;
2) measurement; and
3) functional analysis;

of the relationship between environment and behavior.

Behavioral Health Treatment means:

1) counseling and treatment programs, when provided by a licensed provider; and
2) Applied Behavior Analysis, when provided or supervised by a behavior analyst certified pursuant to the Behavior Analyst Certification Board;

necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of the Covered Person.

Diagnosis of Autism Spectrum Disorder means:

1) assessments;
2) evaluations; or
3) tests;

to diagnose whether the Covered Person has Autism Spectrum Disorder.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care means services provided by licensed or certified:

1) speech therapists;
2) occupational therapists;
3) social workers; or

4) physical therapists.

Treatment of Autism Spectrum Disorder means the following care and assistive communication devices prescribed or ordered by a Physician for a Covered Person diagnosed with Autism Spectrum Disorder:

1) Behavioral Health Treatment;
2) Psychiatric Care;
3) Psychological Care;
4) medical care provided by a licensed health care provider; and
5) Therapeutic Care, including when deemed habilitative or nonrestorative.

Minimum Hospital Stay Benefit for Lymph Node Dissection, Lumpectomy or Mastectomy

To the extent not covered by Medicare, The Policy covers expenses Incurred for Hospital Confinement for a period, as determined by the attending Physician in consultation with the Covered Person, to be medically appropriate for the Covered Person undergoing a:

1) lymph node dissection or lumpectomy for the treatment of breast cancer; or
2) mastectomy.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A Benefits.

Maternity Care Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for Maternity Care provided for the Covered Person, including Hospital, surgical or medical care, the same as any other Sickness covered under The Policy.

Maternity Care means:

1) Inpatient Hospital coverage for mother and newborn for at least:
    a) 48 hours after childbirth for any delivery other than a caesarean section; and
    b) 96 hours after a caesarean section.
2) parent education;
3) assistance and training in breast or bottle feeding;
4) the performance of any necessary maternal and newborn clinical assessments;
5) two payments, at reasonable intervals and for services rendered, for prenatal care; and
6) a separate payment for the delivery and postnatal care provided.

Maternity Care does not include perinatal complications.

The mother has the option to be discharged earlier than the time periods established above. In this case, coverage includes at least one home care visit. This visit is in addition to any other home health care coverage available under The Policy.

The home health care visit may be requested at any time within:

1) 48 hours after any delivery other than a caesarean section; or
2) 96 hours after a caesarean section.

The visit must be delivered within 24 hours:

1) after discharge; or
2) of the time of the mother's request;

whichever is later.

The home health care visit is not subject to any Deductibles, Coinsurance or Copayments.

Except as stated for home health care above, this benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Mental Health Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the diagnosis and treatment of:

1) mental;
2) nervous; or
3) emotional disorders or ailments;

as follows:

1) for Inpatient Hospital care, 30 days of Active Treatment in any Calendar Year;
2) 20 visits in any Calendar Year for Outpatient care provided by:
    a) a psychiatrist or psychologist licensed to practice in the state of New York;
    b) a licensed clinical social worker who meets the requirements of Article 3221 (l) (4) of the New York Insurance Code; or
    c) a professional corporation or one of its university faculty practice corporations.

Benefits for partial hospitalization program services are provided as an offset to covered Inpatient days at a ratio of two partial hospitalization visits to one Inpatient day of treatment.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Active Treatment means treatment furnished in conjunction with Inpatient confinement for:

1) mental;
2) nervous; or
3) emotional disorders or ailments;

that meets standards prescribed pursuant to the regulations of the Commissioner of Mental Health.

Hospital, as used in this provision, means:

1) the Inpatient services of a psychiatric center under the jurisdiction of the Office of Mental Health or other psychiatric Inpatient facility in the department;
2) a psychiatric Inpatient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill;
3) a ward, wing, unit, or other part of a Hospital, as defined in Article 28 of the Public Health Law, operated as a part of the Hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the Commissioner of Mental Health;
4) a comprehensive psychiatric emergency program which has been issued an operating certificate by the Commissioner of Mental Health; or
5) other facility providing Inpatient care or treatment of the mentally ill which has been issued an operating certificate by the Commissioner of Mental Health.

Limitation: This provision does not cover services cosmetic in nature on the grounds that changing or improving the Covered Person's appearance is justified by his or her mental health needs.

Infertility Treatment Benefit

The Policy covers expenses Incurred by Covered Persons from age 21 through age 45 years for:

1) Hospital care, surgical care and medical care for diagnosis and treatment of correctable medical conditions resulting in infertility;
2) surgical or medical procedures to correct malformation, disease or dysfunction resulting in infertility;
3) diagnostic tests and procedures necessary to determine infertility or necessary in connection with any surgical or medical treatments for infertility, including such diagnostic tests and procedures as:
    a) hysterosalpingogram;
    b) hysteroscopy;
    c) endometrial biopsy;
    d) laparoscopy;
    e) sono-hysterogram;

f) post coital tests;
g) testis biopsy;
h) semen analysis;
i) blood tests; or
j) ultrasound; and

4) diagnostic and treatment procedures used in the diagnosis and treatment of infertility.

To be covered, the diagnosis and treatment of infertility must be prescribed as part of a Physician's overall plan of care.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare B Benefits.

Limitations: Coverage under this provision is limited to those Covered Persons who have been insured under The Policy for a period of not less than 12 months at the time treatment starts. However, if The Policy replaced other employer-sponsored individual or group retiree health insurance, "period of not less than 12 months" is determined by calculating the time from the earlier of the date the Covered Person was first covered by:

1) The Policy; or
2) the replaced policy.

Coverage does not include the diagnosis and treatment of infertility in connection with:

1) in vitro fertilization;
2) gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
3) the reversal of elective sterilizations;
4) sex change procedures;
5) cloning; or
6) medical or surgical services or procedures that are deemed to be experimental.

In all other respects the Certificate remains the same.

Signed for Hartford Life and Accident Insurance Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

Extraterritorial Rider

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

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

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

This rider amends Your Certificate, as stated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your Certificate will affect Your coverage. In addition, any reference made to Dependent coverage will only apply if Dependent coverage is provided in Your Certificate. However, if The Policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state the Covered Person resides in as shown below will apply only to the extent that such state requirements are more beneficial to him or her.

For Alabama residents, the Certificate is amended as stated below:

1) The **Time of Payment of Claims** provision is deleted in its entirety and replaced with:

   Benefits payable under this Certificate will be paid within 30 days for an electronic claim or 45 days for a written claim after Our receipt of due written proof of loss.

For Alaska residents:

1) The **Policy Interpretation** provision in the **General Provisions** section is deleted in its entirety.

2) The definition of **Spouse** in the **General Definitions** section is amended to read as follows:

   Spouse means any individual who is recognized as Your spouse under applicable state law.

   Spouse also includes any individual who is Your partner to:
   1) a civil union;
   2) a registered domestic partnership; or
   3) another relationship allowed by state law.

   Spouse will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You and Your partner will continue to be considered affidavit domestic partners provided You and Your Partner continue to meet the requirements described in the domestic partner affidavit.

   Spouse does not include any person who is insured as a Retiree.

If The Policy is issued outside of Arizona and Your former Employer is in Arizona, the Certificate is amended as stated below:

1) The following notice is added to Your Certificate:

   Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

For Arkansas residents, the Certificate is amended as stated below:

1) If part of The Policy, the following provision may be added to Your Certificate:

   In Vitro Fertilization Benefit

   To the extent not covered by Medicare, The Policy covers expenses Incurred for in vitro fertilizations.

   This benefit includes in vitro fertilization services performed at a medical facility licensed or certified by the Department of Health, those performed at a facility certified by the department that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics, or those performed at a facility certified by the department that meets the American Fertility Society minimal standards for programs of in vitro fertilization.

   This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Part B Benefits.

For California residents, the Certificate is amended as stated below:

1) The **Policy Interpretation** provision is deleted in its entirety.

2) **IF YOU ARE AGE 65 OR OLDER ON THE DATE YOU RECEIVE THE CERTIFICATE, THEN THE FOLLOWING APPLIES TO YOU:**

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

For Colorado residents:

1) The **Statements** provision found in the **General Provisions** section is amended as follows:

   In the first sentence, the phrase "In the absence of fraud" is removed.

2) A **Physical Examinations and Autopsy** provision is added to the **Claim Provisions** section as follows:

   Physical Examinations and Autopsy: While a claim is pending, We have the right at Our expense:
   a) to have the Covered Person who has a loss examined by a Physician when and as often as reasonably necessary; and
   b) to make an autopsy in case of death where it is not forbidden by law.

3) The **Conditions Prior to Effective Date of Coverage** and **Conditions Prior to Effective Date of Increase in Coverage** (if applicable) sections in the **Pre-existing Conditions Limitation** section are revised accordingly:

   a) the period of time a Covered Person has to be free of medical care for a claimed condition is limited to a period of six consecutive months that ends on or after the effective date of coverage. If The Policy does not include a free of medical care requirement, the period of time Pre-existing Conditions Limitations applies is limited to six consecutive months from the coverage effective date; and

   b) the period of time a Covered Person has to be free of medical care for an increased benefit is limited to a period of six consecutive months that ends on or after the effective date of coverage. If The Policy does not include a free of medical care requirement, the period of time Pre-existing Conditions

Limitations applies is limited to a period of six consecutive months that ends on or after the effective date of the increased benefit.

4) The **Legal Actions** provision in the **General Provisions** section is deleted in it's entirety and replaced with the following:

   Legal Actions: No legal action may start:
   a) until 30 days if filed electronically otherwise 45 days after proof of loss has been given; or
   b) more than 3 years after the time proof of loss is required to be given.

5) The **Time of Payment of Claims** provisions in the **Claim Provisions** section is deleted in its entirety and replaced with the following:

   Time of Payment of Claims: Benefits payable under this Certificate will be paid within 30 days if filed electronically otherwise 45 days after Our receipt of due written proof of loss.

For Delaware residents, the Certificate is amended as stated below:

1) The Policy provides parties to a civil union and their Medicare Eligible Dependent Children with identical benefits, rights and protections as those afforded to married Spouses and their Medicare Eligible Dependent Children.

2) The following provision is added to Your Certificate:

Breast Reconstructive Surgery Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the following if the Covered Person has had a mastectomy:
1) all stages of reconstruction of the breast on which the mastectomy has been performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The provision of services must be determined in consultation with the attending Physician and the Covered Person.

This benefit is paid subject to the conditions, terms, limitations and exclusions other applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

3) The following provision is added to Your Certificate:

Hair Prosthesis Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for a Scalp Hair Prosthesis worn for hair loss suffered by the Covered Person as a result of alopecia areata, resulting from autoimmune disease.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits. However, in no event will the amounts paid under this benefit for alopecia areata exceed $500 per Calendar Year.

Scalp Hair Prosthesis means artificial substitutes for scalp hair that are made specifically for a Covered Person.

4) The Policy provides coverage for the following screening found in the **Preventive Care Cancer Screening Benefit**:

   1) one ovarian cancer surveillance test each Calendar Year ordered by a Physician;

For Idaho residents:

1) The **Conditions Prior to Effective Date of Coverage** provision in the **Pre-existing Conditions Limitation** section is amended to not exceed the first 12 continuous months of the Covered Person's coverage.

2) The **Conditions Prior to Effective Date of Increase in Coverage** provision in the **Pre-existing Conditions Limitation** section is amended to not exceed the first 12 continuous months following the effective date of a change in the Covered Person's coverage that increases the Covered Person's benefits.

3) The first paragraph of the **Pre-existing Condition** definition in the **Pre-existing Conditions Limitation** section is amended as follows:

   Pre-existing Condition means any Injury or Sickness for which medical care is received by the Covered Person within the 6 consecutive months prior to the date the Covered Person's insurance starts.

4) The first paragraph of the **Pre-existing Condition** definition in the **Pre-existing Conditions Limitation** section is amended as follows:

   Pre-existing Condition means any Injury or Sickness for which medical care is received by the Covered Person within the 6 consecutive months prior to the effective date of the Covered Person's increase in coverage.

For Illinois residents, the Certificate is amended as stated below:

1) The following provision is added to Your Certificate:

Breast Reconstructive Surgery Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for Prosthetics or reconstructive surgery if the Covered Person has had mastectomy. Coverage for breast reconstruction in connection with a mastectomy shall include:

1) reconstruction of the breast upon which the mastectomy has been performed;
2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3) prostheses and treatment for physical complications at all stages of a mastectomy, including lymphedemas.

The provision of services must be determined by the attending Physician and the Covered Person.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits; however when a mastectomy is performed and there is no evidence of malignancy, then the offered coverage may be limited to the provision of Prosthetic devices and reconstructive surgery to within 2 years after the date of the mastectomy.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons, as determined by a Physician.

2) The Policy provides coverage for the following screenings found in the **Preventive Care Cancer Screening Benefit:**

   1) thorough clinical breast examinations as indicated by guidelines of practice, performed by a Physician, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a physician assistant who has been delegated authority to provide breast examinations, to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:
      a) at least every 3 years for women at least 20 years of age but less than 40 years of age; and
      b) annually for women 40 years of age or older;
   2) Low-dose Mammography of occult breast cancer of all women 35 years of age or older conducted by test facilities accredited by the American College of Radiologists as follows:
      a) a baseline mammogram for women 35 to 39 years of age;
      b) an annual mammogram for women 40 years of age or older;
      c) a mammogram at the age and intervals considered Medically Necessary by the woman's health care provider for women under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors; and

d) a comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician.

3) one colon cancer screening each Calendar Year ordered by a Physician

3) The Policy provides parties to a Civil Union and their Medicare Eligible Dependent Children with identical benefits, rights and protections as those afforded to married Spouses and their Medicare Eligible Dependent Children.

For Kansas residents, the Certificate is amended as stated below:

The **Policy Interpretation** provision is deleted in its entirety.

For Kentucky residents, the Certificate is amended as stated below:

1) The Policy provides coverage for the following screenings found in the **Preventive Care Cancer Screening Benefit**:

   1) The following low-dose Mammography Screening conducted by a facility which meets the current criteria of the American College of Radiology Mammography Accreditation Program:
      a) one mammogram for a woman 35 through 39 years of age;
      b) one mammogram every two years for a woman 40 through 49 years of age;
      c) one mammogram per year for a woman 50 years of age or older; or
      d) one mammogram for a woman, regardless of age, who have been diagnosed with breast disease by a Physician.

   Mammography Screening shall mean an x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, with two views of each breast and with an average radiation exposure at the current recommended level as set forth in guidelines of the American College of Radiology.

2) Kentucky requires that We offer the following benefit to its residents. Please see your Policyholder to confirm if this benefit is available to You.

Mastectomy and Breast Reconstructive Surgery Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the following if the Covered Person has had a mastectomy:

1) surgery and reconstruction of the breast on which the mastectomy has been performed;
2) surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The provision of services must be determined in consultation with the attending Physician and the Covered Person.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

3) Kentucky requires that We offer the following benefit to its residents. Please see your Policyholder to confirm if this benefit is available to You.

Endometriosis and Endometritis Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the diagnosis and treatment of endometriosis and endometritis.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

4) Kentucky requires that We offer the following benefit to its residents. Please see your Policyholder to confirm if this benefit is available to You.

Osteoporosis Screening Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for bone density testing for women age 35 years and older, as indicated by the health care provider, in accordance with standard medical practice, to obtain baseline data for the purpose of early detection of osteoporosis.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

For Maine residents, the Certificate is amended as stated below:

Third Party Notice of Cancellation

Maine Law provides for Third-Party Notice Request Form, which means You are allowed the right to designate an additional person to receive notice of any intent to cancel a contract of coverage.

Reinstatement of Coverage and Cognitive Impairment or Functional Incapacity

Reinstatement of Coverage and Cognitive Impairment or Functional Incapacity: Within 90 days after termination of Your insurance under The Policy due to Your non-payment of premium, You, any person authorized to act on Your behalf or any of Your Dependents insured under The Policy may request reinstatement of Your coverage on the basis that You suffered from cognitive impairment or functional incapacity at the time of termination of Your coverage.

We may request a medical demonstration that You suffered from cognitive impairment or functional incapacity at the time of termination of Your coverage. If the demonstration is waived, or substantiates the existence of cognitive impairment or functional incapacity at the time of termination to Our satisfaction, Your coverage shall be reinstated. The medical demonstration shall be at Your expense. The reinstated coverage shall:

1) be provided without any evidence of insurability;
2) cover loss occurring from the date of termination of Your coverage; and
3) be at the level provided immediately before the termination.

Premium must be paid from the date of the last premium payment at the rate which would have been in effect had Your coverage remained in force. Payment must be made within 15 days after Our request for payment. If the premium is not paid as required, We have no obligation to reinstate Your coverage. If the coverage is not reinstated, claims incurred after the date of termination are not covered.

You also have the right to reinstate Your coverage, subject to the conditions and procedures set forth above, if termination is for any other lapse or default on Your part, provided that the default is cured promptly and an adequate causal connection is made between the default and Your cognitive impairment or functional incapacity.

For Massachusetts residents, the Certificate is amended as stated below.

Hormone Replacement Therapy Services and Contraceptive Services Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for:

1) hormone replacement therapy services for peri and post menopausal women; and
2) Outpatient Contraceptive Services.

Outpatient Contraceptive Services means:

1) consultations;
2) examinations;
3) procedures; and
4) medical services;

related to the use of all contraceptive methods approved by the United States Food and Drug Administration to prevent pregnancy.

Exclusion: This benefit is not available when the coverage under The Policy is obtained through an employer that is a:

1) church; or
2) qualified church-controlled organization;

as defined in Title 26 U.S.C. Section 3121(w)(3)(A) and (B).

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare B Benefits.

Preventive Cancer Screening Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for:

1) an annual cytologic screening for women 18 years of age and older;
2) a baseline mammogram for women between the ages of 35 and 40; and
3) a mammogram on an annual basis for women 40 years of age and older.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Additional Plan Benefits.

Diagnosis and Treatment of Autism Spectrum Disorders Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the Diagnosis and Treatment of Autism Spectrum Disorders.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare B Benefits. However, the coverage under this provision is not subject to any limits on the number of visits to an Autism Services Provider. Pharmacy Care is provided under this provision only to the same extent as it is provided under The Policy for other medical conditions.

The following terms have the meanings as shown below:

Applied Behavior Analysis means the:

1) design;
2) implementation; and
3) evaluation of environmental modifications;

using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of:

1) direct observation;
2) measurement; and
3) functional analysis;

of the relationship between environment and behavior.

Autism Services Provider means:

1) a person;
2) an entity; or
3) a group;

that provides Treatment of Autism Spectrum Disorders.

Autism Spectrum Disorders means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including:

1) autistic disorder;
2) Asperger's syndrome; and
3) pervasive developmental disorders not otherwise specified.

Board Certified Behavior Analyst means a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

Diagnosis of Autism Spectrum Disorders means Medically Necessary assessments and evaluations, including:

1) neuropsychological evaluations;
2) genetic testing; and
3) other tests;

to diagnose whether a Covered Person has one of the Autism Spectrum Disorders.

Habilitative or Rehabilitative Care means professional, counseling and guidance services and treatment programs, including, but not limited to, Applied Behavior Analysis supervised by a Board Certified Behavior Analyst that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a Covered Person.

Pharmacy Care means:
1) medications prescribed by a Physician; and
2) health-related services;

deemed Medically Necessary to determine the need or effectiveness of medications.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care means services provided by licensed or certified:
1) speech therapists;
2) occupational therapists;
3) physical therapists; and
4) social workers.

Treatment of Autism Spectrum Disorders means the following care when prescribed, provided or ordered for a Covered Person diagnosed with one of the Autism Spectrum Disorders by a Physician or a licensed psychologist who determines the care to be Medically Necessary:
1) Habilitative or Rehabilitative Care;
2) Pharmacy Care;
3) Psychiatric Care;
4) Psychological Care; and
5) Therapeutic Care.

Hearing Aids for Minors Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the following by any child 21 years of age or younger who is insured under The Policy:
1) one hearing aid per hearing impaired ear;
2) all related services prescribed by a licensed audiologist or hearing instrument specialist;
3) the initial hearing aid evaluation;
4) fitting and adjustments; and
5) supplies, including ear molds;

subject to Our being provided a written statement from the child's treating Physician that the hearing aids are necessary regardless of etiology.

Benefits are payable up to $2,000 for each hearing impaired ear every 36 months.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits. If The Policy includes the Hearing Services Benefit, then benefits for the covered child will paid according to the Hearing Services Benefit if they are more beneficial than those payable under the Hearing Aids for Minors Benefit.

Speech, Hearing and Language Disorders Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the Medically Necessary diagnosis and treatment of disorders of the following by licensed speech-language pathologists or audiologists:
1) speech;
2) hearing; and
3) language.

Diagnosis and treatment are covered regardless of whether provided in a:

1) Hospital;
2) clinic; or
3) private office.

Exclusion: This benefit does not cover treatment provided in a school-based setting.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A Benefits and Medicare Part B Benefits.

For Michigan residents, the Certificate is amended as stated below:

1) The following provision is deleted in its entirety from Your Certificate:

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, as amended (ERISA).

For Minnesota residents, the Certificate is amended as stated below:

1) The following is deleted in its entirety from the **Exclusions**:

"any expense Incurred for a condition contributed to by, caused by, or resulting from, the Covered Person's commission, or attempted commission, of a felony."

It is replaced by the following:

"any expense Incurred for a condition for which a contributing cause was the Covered Person's commission, or attempted commission, of a felony."

2) The **Time of Payment of Claims** provision is deleted in its entirety from the **Claim Provisions**. It is replaced by the following:

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately after Our receipt of due written proof of loss.

3) The following sentence is deleted in its entirety from the **Notice of Claim** provision:

"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."

It is replaced by the following:

"Notice given by or on behalf of a Covered Person to Us at Our Home Office, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us."

4) The following is added to the **Claim Provisions**:

Physical Examinations and Autopsy: We, at Our own expense, may:
1) examine the Covered Person when and as often as We may reasonably require during the pendency of a claim under The Policy; and
2) make an autopsy in case of death where it is not forbidden by law.

5) The **Misstatement of Age** provision is deleted in its entirety from the **General Provisions**. It is replaced by the following:

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

6) The following benefit provisions are added to the Certificate:

Outpatient Treatment and Surgery Benefit: To the extent not covered by Medicare, The Policy covers health care treatment and surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a Hospital. Coverage will be on the same basis as coverage for the same health care treatment when received, or for surgery when performed, in a Hospital.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

Diabetes Coverage Benefit: For Covered Persons with gestational, type I or type II diabetes, The Policy covers all Physician prescribed Medically Necessary:

1) equipment and supplies used in the management and treatment of diabetes; and
2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

"Medically Necessary equipment and supplies" as used above includes both oral and injectable insulin.

This benefit is paid subject to the conditions, terms, limitations and exclusions applicable to the The Policy's Medicare Part B Benefits.

Temporomandibular Joint Disorder and Craniomandibular Disorder Treatment Benefit: To the extent not covered by Medicare, The Policy covers treatment of temporomandibular joint disorder and craniomandibular disorder to the same extent as any other Sickness which is covered under The Policy, provided the treatment is administered or prescribed by a Physician or dentist.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

Lyme Disease Benefit: To the extent not covered by Medicare, The Policy covers treatment of Lyme Disease to the same extent as any other Sickness which is covered under The Policy.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Reconstructive Surgery Benefit: To the extent not covered by Medicare, The Policy covers reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered Medicare Eligible Dependent Child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which a Medically Necessary mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a Medically Necessary mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and patient.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Scalp Hair Prosthesis Benefit: To the extent not covered by Medicare, The Policy covers one scalp hair prosthesis per Calendar Year when prescribed for hair loss suffered as a result of alopecia areata.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

Phenylketonuria Benefit: To the extent not covered by Medicare, The Policy covers special dietary treatment for phenylketonuria when recommended by a Physician.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Newborn Child Benefit: To the extent not covered by Medicare, The Policy covers newborn Medicare Eligible Dependent Children immediately from the moment of birth and thereafter for illness, injury, congenital malformation, or premature birth. This includes inpatient and outpatient expenses arising from medical and dental treatment, including dental orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate provided such treatment was scheduled or initiated prior to age nineteen.

If the Medicare Eligible Dependent Child is covered under a dental insurance plan for orthodontia services that plan shall be the primary. Dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate are not covered under this benefit.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Child Health Supervision and Prenatal Services Benefit: To the extent not covered by Medicare, The Policy covers pediatric preventive services, appropriate immunizations, developmental assessments, and laboratory services appropriate to the age of a Medicare Eligible Dependent Child from birth to age six, and appropriate immunizations from ages six to eighteen, as defined by the Standards of Child Health Care issued by the American Academy of Pediatrics. This benefit includes at least five child health supervision visits from birth to twelve months, three child health supervision visits from twelve months to twenty-four months, and once a year from twenty-four months to seventy-two months.

Prenatal services include medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by the Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Port-Wine Stain Hemangioma Benefit: To the extent not covered by Medicare, The Policy covers elimination or maximum feasible treatment of port wine stain hemangiomas.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Dental Care Anesthesia and Hospital Charges Benefit: To the extent not covered by Medicare, The Policy covers anesthesia and hospital charges for dental care provided to an Insured Person or Dependent who:

1) is a Medicare Eligible Dependent Child under age five;
2) is severely disabled; or
3) has a medical condition,

and who requires hospitalization or general anesthesia for dental care treatment.

This benefit includes general anesthesia and treatment for a medical condition rendered by a dentist in a dental office.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Autism Spectrum Disorder Benefit: To the extent not covered by Medicare, The Policy covers diagnosis, evaluation, multidisciplinary assessment, and Medically Necessary Care of Medicare Eligible Dependent Children under age eighteen with Autism Spectrum Disorders, including but not limited to the following:

1) early intensive behavioral and developmental therapy based on behavioral and developmental science, including but not limited to, all types of applied behavioral analysis, intensive early intervention behavior therapy, and intensive behavior intervention;
2) neurodevelopmental and behavioral health treatments and management;
3) speech therapy;
4) occupational therapy;
5) physical therapy; and
6) medication.

The diagnosis, evaluation, and assessment must include an assessment of the Medicare Eligible Dependent Child's developmental skills, functional behavior, needs, and capacities. This benefit includes treatment that is in accordance with an individualized treatment plan prescribed by the Medicare Eligible Dependent Child's treating Physician or a mental health professional who has training and expertise in Autism Spectrum Disorder and child development.

We may request an updated treatment plan only once every six months unless We and the treating Physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

An independent progress evaluation conducted by a mental health professional with expertise and training in Autism Spectrum Disorder and child development must be completed to determine if progress toward function and generalized gains, as determined in the treatment plan, are being made.

Autism Spectrum Disorder means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For the purposes of the this benefit, Medically Necessary Care means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the Medicare Eligible Dependent Child's condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by Physicians and licensed psychologists who typically manage patients who have Autism Spectrum Disorders.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

Emotionally Disabled Child Treatment Benefit: To the extent not covered by Medicare, The Policy covers treatment of a Medicare Eligible Dependent Child while in a residential treatment facility due to emotional disability, as set forth by the commissioner of human services in the rules relating to residential treatment facilities. For the purposes of this benefit only, a residential treatment facility is considered a hospital providing inpatient care.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A Benefits.

Maternity Care Benefit: To the extent not covered by Medicare, The Policy covers a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her Medicare Eligible Dependent Child.

If the duration of inpatient care is less than the minimum provided above, this benefit will also provide post delivery care to a mother and her Medicare Eligible Dependent Child consisting of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to parent education, assistance and training in breast and bottle feeding, and conducting any necessary and appropriate clinical tests. The home visit must be conducted within four days following the discharge of the mother and her Medicare Eligible Dependent Child.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

7) The **Pre-existing Conditions Limitation** provision is deleted in its entirety.

8) The following sentence is added to the **Termination of Your Coverage** provision:

   We will not cancel or nonrenew The Policy on the grounds of Your health status.

9) The following provision is added to the **Eligibility and Effective Dates** section:

   Suspension of Coverage: If, after obtaining this coverage, You become eligible for Medicaid, the benefits and premiums under Your Group Retiree Insurance Plan® certificate can be suspended if requested during Your entitlement to benefits under Medicaid for twenty-four months. You must request this suspension within ninety days of becoming eligible for Medicaid.

If You are no longer entitled to Medicaid and Your suspended Group Retiree Insurance Plan® certificate is still available, then Your coverage will be reinstated. You must request this reinstatement within ninety days of losing Medicaid eligibility.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

10) The following provision is added to the **Continuation Provisions** section:

Inpatient Confinement at the time of Policy Termination: If, on the date the Policyholder terminates The Policy, a Covered Person is confined as an Inpatient in a licensed Hospital or Skilled Nursing Facility coverage will continue until the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

11) The **Divorced Spouse Continuation** provision is added to the **Continuation Provisions** section, if not already included, only when **Dependent Spouse** coverage is offered:

Divorced Spouse Continuation: If You and Your Spouse Divorce while Your Spouse is covered under The Policy, Your Spouse may continue his or her coverage. We must receive Your Spouse's Request and the required premium to continue the coverage within 31 days of the date Your Spouse's coverage terminates. Solely for the purpose of continuing the coverage under The Policy, the Spouse will then be considered the Primary Insured.

However, Your Spouse's coverage will not continue after the earliest of:

1) a date the coverage would normally end under Termination of Your Dependents' Coverage; or
2) the Premium Due Date Your Spouse becomes covered under any other group health plan.

Divorce or **Divorced** means legal divorce.

12) The **Medicare Eligible Dependent Child Continuation after Divorce** provision is added to the **Continuation Provisions** section, if not already included, only when **Medicare Eligible Dependent Child** coverage is offered:

Medicare Eligible Dependent Child Continuation after Divorce: If You and Your Spouse Divorce while Your Medicare Eligible Dependent Child is covered under The Policy, Your Medicare Eligible Dependent Child may continue his or her coverage. We must receive Your Medicare Eligible Dependent Child's Request and the required premium to continue the coverage within 31 days of the date Your Medicare Eligible Dependent Child's coverage terminates. Solely for the purpose of continuing the coverage under The Policy, the Spouse will then be considered the Primary Insured.

However, Your Medicare Eligible Dependent Child's coverage will not continue after the earliest of:

1) a date the coverage would normally end under Termination of Your Dependents' Coverage; or
2) the Premium Due Date Your Medicare Eligible Dependent Child becomes covered under any other group health plan.

Divorce or **Divorced** means legal divorce**.**

13) The **Surviving Dependent Continuation** provision is deleted in its entirety from the **Continuation Provisions** section. It is replaced with the following:

Surviving Dependent Continuation: If You die while insured under The Policy, coverage for Your Dependents that is in force on the date of Your death may be continued, until the earliest of:

1) the date the coverage would otherwise have ended under Termination of Your Dependents' Coverage; or
2) the date Your Spouse obtains coverage under another group plan.

We must receive Your Dependents' Request and the required premium to continue the coverage within 90 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the Primary Insured.

14) The following notice is added to the first page of the Certificate:

Notice to buyer: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask for further details.]

15) The READ YOUR CERTIFICATE CAREFULLY notice on the first page of the Certificate is deleted in its entirety. It is replaced by the following:

READ YOUR CERTIFICATE CAREFULLY: You have a 30 day right to examine Your Certificate. If You are not satisfied for any reason, You may return it to Us within 30 days from the date You received it. In that event, We will consider it void from Your Coverage Effective Date and any premiums paid will be refunded within 10 days.

For Montana residents, the Certificate is amended as stated below:

1) The definition of **Medicare Eligible Dependent Child(ren)** is deleted in its entirety. It is replaced by the following definition:

Medicare Eligible Dependent Child(ren) means:

1) Your unmarried child, stepchild, legally adopted child;
2) any child for whom You have legal guardianship; or
3) any other child related to You by blood or marriage or, as allowed by The Policy, domestic partnership or civil union;

who is entitled to Medicare by reason of age or disability, as provided by The Policy, and, if applicable to the Certificate, for whom You have requested coverage, as allowed by The Policy, but who is not:

1) an employee eligible for coverage under a group health plan offered by the child's employer for which the child's premium contribution amount is no greater than the premium amount for coverage as a dependent under a parent's individual or group health plan; or
2) a named subscriber, insured, enrollee, or covered individual under any other individual health insurance coverage, group health plan, government plan, church plan, or group health insurance.

No person may be considered to be a Medicare Eligible Dependent Child of more than one Primary Insured.

2) The following provision is added to Your Certificate:

Breast Reconstruction Benefit

The Policy covers all stages of reconstruction of the breast on which a mastectomy has been performed.

3) The following provision is added to Your Certificate:

Breast Cancer Treatment Benefit

In accordance with the Hospital Confinement Benefit and Extended Hospital Confinement Benefit, The Policy covers Hospital Inpatient care for a period of time as is determined by the attending Physician, in consultation with the Covered Person, to be Medically Necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer.

4) The following provision is added to Your Certificate:

Maternity Services for Childbirth Benefit

In accordance with the Hospital Confinement Benefit, The Policy covers at least 48 hours of Inpatient Hospital care following a vaginal delivery and at least 96 hours of Inpatient Hospital care following delivery by cesarean section for the Covered Person and newborn infant in a Hospital.

For Nebraska residents, the Certificate is amended as stated below:

1) The following provision is added to Your Certificate:

Orally Administered Chemotherapy Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for treatment of cancer through the use of chemotherapy administered orally by means of a prescription drug used to kill or slow the growth of cancerous cells.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

2) The following in the **Preventive Care Cancer Screening** provision was deleted in its entirety:

    2) One colon cancer screening each Calendar Year ordered by a Physician

    It is replaced by the following:

    2) colon screening for a colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic Covered Person who is 50 years of age or older. Such screening shall be deemed appropriate by a health care provider and the Covered Person and will include:
        a) a maximum of one screening fecal occult blood test per Calendar Year and a flexible sigmoidoscopy every five years;
        b) a colonoscopy every ten years;
        c) a barium enema every five to ten years; or
        d) any combination, or the most reliable, medically recognized screening test available.

For Nevada residents, the Certificate is amended as stated below:

1) The following notice is added to Your Certificate:

    This limited health benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

For New Hampshire residents, the Certificate is amended as stated below.

1) The following is deleted from the definition of **Hospital**:

    5) a military or veterans' hospital, soldiers' home, or hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the military.

    It is replaced by the following:

    5) a military or veterans' hospital, soldiers' home, or hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the military, except for services rendered on an emergency basis where a legal liability for the Covered Person exists for charges made to him or her for the services.

2) In the **Conditions Prior to Effective Date of Coverage** paragraph in the **Pre-Existing Conditions Limitation**, the period during which We will not pay a benefit under The Policy for any expenses Incurred due to a Pre-Existing Condition will be the lesser of the period stated in the Certificate or 1 year.

3) In the **Conditions Prior to Effective Date of Increase in Coverage** paragraph in the **Pre-Existing Conditions Limitation**, the period during which We will not pay a benefit under The Policy for any expenses Incurred due to a Pre-Existing Condition will be the lesser of the period stated in the Certificate or 1 year.

4) The **Proof of Loss** provision is deleted in its entirety. It is replaced by the following:

    Proof of Loss: The claimant must send written proof of loss to Us. This proof must be provided within 1 year after the date of the loss. Failure to furnish proof within such time shall not invalidate nor reduce any claim if:
    1) it is shown not to have been reasonably possible to furnish such proof; and
    2) proof was furnished as soon as was reasonably possible.

5) The following provision is added to the Certificate:

Physical Examinations and Autopsy: We, at Our own expense, may:
1) examine the Covered Person when and as often as We may reasonably require during the pendency of a claim under The Policy; and
2) make an autopsy in case of death where it is not forbidden by law.

6) The **Statements** provision is deleted in its entirety. It is replaced by the following:

Statements: All statements made by a Covered Person will be considered representations and not warranties.

7) The following provision is added to Your Certificate:

Spouse Continuation Following Divorce or Legal Separation

If there is Spouse coverage under The Policy, then upon a final decree of divorce or legal separation, Your former Spouse shall be, and shall remain, eligible for benefits under The Policy, without additional premium or examination, as if the decree had not been issued, unless the decree expressly provides otherwise.

You or Your former Spouse must submit to Us evidence of the former Spouse's eligibility under this provision within 30 days after the final decree of divorce or legal separation. If The Policy replaced another group policy issued by a different insurance carrier, You or Your former Spouse must submit evidence of the former Spouse's eligibility under the Prior Policy's continuation provision for divorce or legal separation within 30 days following the effective date The Policy. If We determine that the former Spouse is eligible, then his or her coverage under The Policy takes effect as of:
1) the date of the final decree of divorce or legal separation occurring while The Policy is in force; or
2) the effective date of The Policy if continuation of coverage for the former Spouse was in force under the Prior Policy.

The former Spouse must notify Us, in writing, of any address, other than Your address, to which notices and correspondence pertaining to the former Spouse's coverage should be mailed, including, but not limited to, notice of cancellation and any right to reinstate coverage. We shall use such address until We receive written notice from the former Spouse of a change.

Termination Events: If Your former Spouse elects coverage under this provision, then coverage continues in force, subject to the payment of premium, until the earliest of the following Termination Events:
1) the date The Policy terminates;
2) the 3 year anniversary of the final decree of divorce or legal separation;
3) the date Your former spouse remarries;
4) the date You remarry;
5) the date of Your death; or
6) such earlier time as provided by the final decree of divorce or legal separation.

If Your former Spouse remarries, the former Spouse must notify Us, in writing, within 30 days after the date of remarriage.

Additional Continuation Following Termination Events: Upon the occurrence of the earliest of the Termination Events above, other than the remarriage of Your former Spouse, the former Spouse may continue coverage by submitting a Request:
1) within 30 days after the applicable Termination Event; or
2) if the Termination Event is Your remarriage or death, within 30 days after receiving notice of the event.

The period of coverage under this section will be:
1) 36 months for Termination Events 3), 5), 6) and 7); or
2) for Termination Events 1 or 2), the lesser of:
    a) 39 weeks; or
    b) the remaining period for which coverage would have continued, subject to Termination Events 3), 5), 6) or 7), as applicable, had The Policy remained in force.

The premium charged to the individual electing additional continuation of coverage shall not exceed 102% of the group premium amount as allocated for that individual's coverage. The individual must pay premiums directly to Us, subject to a 30 day grace period for unpaid premiums, during which coverage remains in force.

8) The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.

For New Mexico residents, the Certificate is amended as stated below:

Alpha-fetoprotein IV screening

To the extent not covered by Medicare, The Policy covers expenses Incurred by the Covered Person for one alpha-fetoprotein IV screening test for pregnant women, between sixteen and twenty weeks of pregnancy, to screen for genetic abnormalities in the fetus.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Circumcision Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for circumcision of a Covered Person's newborn male.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

Orally Administered Cancer Chemotherapy Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for the treatment of orally administered cancer chemotherapy at dollar limits, copayments, deductibles, or coinsurance rates no less favorable than those payable for cancer chemotherapy administered intravenously or by injection.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits.

For North Carolina residents, the Certificate is amended as stated below:

1) The following notice is added to the face page of the Certificate:

THIS CERTIFICATE CONTAINS A PRE-EXISTING CONDITIONS LIMITATION.

2) In the **Conditions Prior to Effective Date of Coverage** and **Conditions Prior to Effective Date of Increase in Coverage** paragraphs in the Pre-Existing Conditions Limitation, the period during which We will not pay a benefit under The Policy for any expenses Incurred which are the result of a Pre-Existing Condition will be the lesser of:
   a) the period stated in the Certificate; or
   b) 1 year.

   There is no change in the period for which the Covered Person must have been free of medical care, if included in the Certificate.

3) In the definition of **Pre-Existing Condition** in the **Pre-Existing Conditions Limitation**, the time period within which medical care may have been received prior to coverage, or an increase in coverage, taking effect will be the lesser of:
   a) the period stated in the Certificate; or
   b) 12 consecutive months.

4) If The Policy is held by an out-of-state trust, the following applies to the Certificate:

   No change to The Policy shall be valid:
   a) until approved by one of Our executive officers; and
   b) unless such approval is endorsed on, or attached to, The Policy.

5) If The Policy is held by an out-of-state trust, the **Time Limit on Certain Defenses** provision is deleted in its entirety. It is replaced by the following:

   Time Limit on Certain Defenses: After a Covered Person has been insured under The Policy for 2 years during his or her lifetime, no statement made by him or her will be used to reduce or deny a claim beginning after the 2 year period. To be used, the statement must:
   1) be in writing;
   2) be signed by the Covered Person who made it; and
   3) a copy must be given to him or her.

   If the Covered Person is not of the age of majority, then the statement must be signed by the Primary Insured.

6) If The Policy is held an out-of-state trust, written notice of claim must be given to Us at Our Home Office within the time frame stated in the **Notice of Claim** provision of the Certificate after the start of any loss covered by the Certificate, or as soon as is reasonably possible.

7) If The Policy is held by an out-of-state trust, the **Proof of Loss** provision is deleted in its entirety. It is replaced by the following:

   Proof of Loss: The claimant must send written proof of loss to Us. This proof must be provided within 180 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of Loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

8) If The Policy is held by an out-of-state trust, the **Time of Payment of Claims** provision is deleted in its entirety. It is replaced by the following:

   Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately after Our receipt of due written proof of loss.

For North Dakota residents, the Certificate is amended to include the following provision, if not already part of the Certificate:

Temporomandibular Joint Disorder Benefit

To the extent not covered by Medicare, The Policy covers expenses Incurred for diagnostic and surgical treatment that is Medically Necessary for temporomandibular joint disorder.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part B Benefits. However, in no event will the amount paid under this benefit exceed the greater of:
1) a lifetime maximum of ten thousand dollars per Covered Person for surgery; or
2) two thousand five hundred dollars per Covered Person for nonsurgical treatment.

For Ohio residents, the Certificate is amended as stated below:

1) The following provision is added to Your Certificate:

   Overpayment Recovery from a Provider: We have the right to recover any amount that We determine to be an overpayment if the overpayment recovery process is initiated with 2 years after the payment was made by Us.

   A written notice of overpayment will be provided to the provider. If the provider:
   1) fails to respond to the notice of overpayment within 30 days after the notice of overpayment is made;
   2) elects not to appeal the determination; or
   3) appeals the determination but the appeal is not upheld;

   We may initiate recovery of the overpayment.

   When a provider has failed to respond within 30 days after the notice of overpayment is made, We have the right to:

1) reduce or offset against any future benefits payable to the provider until full reimbursement is made;
2) refer the unpaid balance to a collection agency; and
3) pursue and enforce all legal and equitable rights in court.

When a provider elects not to appeal the determination of overpayment or appeals the determination but the appeal is not upheld, We will permit the provider to repay the amount:

1) by making one or more direct payments to Us; or
2) by having the amounts reduce or offset against any future benefits payable to the provider until full reimbursement is made.

2) The **Overpayment Recovery** provision in Your Certificate is revised to:

Overpayment Recovery from You: We have the right to recover any amount that We determine to be an overpayment. In the absence of an assignment, as described in Assignment of Benefit Payments above, You have the obligation to reimburse Us any such amount within 90 days after the date of the overpayment.

If You do not reimburse Us 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; and
    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.

Notwithstanding the foregoing, We may only recover overpayments from a provider as stated in the following provision.

For Oklahoma residents, the Certificate is amended as stated below:

1) The following statement from the **Overpayment Recovery** provision is deleted in its entirety:

We have the right to recover any amount that We determine to be an overpayment.

It is replaced with the following statement:

We have the right to recover any amount that We determine to be an overpayment within 24 months of the overpayment.

For Oregon residents, the Certificate is amended as stated below:

1) Notwithstanding any provision to the contrary, coverage for domestic partners is included if coverage for Spouses is included in The Policy. The following changes apply to Your Certificate if domestic partners are not already covered under The Policy along with Spouses:

    a) The definition of **Family Member** is amended to include “domestic partner”;

    b) The definition of **Medicare Eligible Dependent Child(ren)**, if included in Your Certificate, is amended to include any other child related to You by “domestic partnership”;

    c) The definition of **Spouse** is amended to include a “registered domestic partnership”;

    d) The definition of **Spouse** is amended to include the following:

    Spouse will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You and Your partner will continue to be considered affidavit domestic partners provided You and Your Partner continue to meet the requirements described in the domestic partner affidavit.;

e) The reference to “remarry”, if any, in the **Termination of Your Coverage** provision is amended to include “or execute a domestic partner affidavit”; and

f) The **Divorced Spouse Continuation** provision, if included in Your Certificate, is amended as follows:
   i. The reference to “remarries” is amended to include “or executes a domestic partner affidavit”;
   ii. The definition of **Divorce or Divorced** is amended to include “termination of a domestic partnership”; and

g) The reference to “remarries” in the **Surviving Dependent Continuation** provision, if included in Your Certificate, is amended to include “or executes another domestic partner affidavit”.

2) The following restriction in the **Eligibility Restriction** provision is deleted in its entirety:

   2) is covered by Medicaid for medical coverage.

3) The reference in the **Insurance Fraud** provision that insurance fraud “is a crime” is deleted and replaced by the following:

   “may be a crime”.

For Rhode Island residents, the Certificate is amended as stated below:

1) The **Policy Interpretation** provision is deleted in its entirety:

   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, as amended (ERISA).

For South Dakota residents, the Certificate is amended as stated below:

1) The following is added to the **Hospital** provision in its entirety:

   Hospital may also include a facility licensed in South Dakota which has an organized medical staff with permanent facilities including inpatient beds and which is primarily engaged in providing diagnostic or therapeutic services for medical diagnosis, treatment or care of injured and disabled, rehabilitation service for the physical rehabilitation of the injured and disabled, either on its premises or in facilities under the supervision of Physicians on a pre-arranged basis to inpatients.

2) The following in the **Hospital** provision is deleted in its entirety:

   2) a place for rest, custodial, educational or rehabilitative care;

   It is replaced by the following:

   2) a place for rest, custodial, educational or, except as stated above, rehabilitative care;

3) The following in the **Physician** provision is deleted in its entirety:

   4) not the Covered Person or a Family Member.

   It is replaced by the following:

   4) not the Covered Person or a Family Member, unless such Family Member is the only Physician in the area of residence of the Covered Person.

4) The following in the **Chiropractic Services Benefit** provision is added in its entirety:

   The Policy Copayment and the Policy Coinsurance for covered Chiropractic Services will not be greater than the amounts under The Policy’s Medicare Part B benefits for other services.

5) The following in the **Pre-Existing Conditions Limitation** provision is deleted in its entirety:

Conditions Prior to Effective Date of Coverage: We will not pay a benefit under The Policy for any expenses Incurred:

1) during the first 2 years of the Covered Person's coverage; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 12 consecutive months ending on or after the Covered Person's effective date of coverage.

Conditions Prior to Effective Date of Increase in Coverage: We will not pay an increased benefit under The Policy for any expenses Incurred:

1) during the first 2 years following the effective date of a change in the Covered Person's coverage that increases the Covered Person's benefits; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 12 consecutive months ending on or after the Covered Person's effective date of benefit increase.

It is replaced by the following:

Conditions Prior to Effective Date of Coverage: We will not pay a benefit under The Policy for any expenses Incurred:

1) during the first 12 consecutive months of the Covered Person's coverage; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 12 consecutive months ending on or after the Covered Person's effective date of coverage.

Conditions Prior to Effective Date of Increase in Coverage: We will not pay an increased benefit under The Policy for any expenses Incurred:

1) during the first 12 consecutive months following the effective date of a change in the Covered Person's coverage that increases the Covered Person's benefits; and
2) which are the result of a Pre-existing Condition;

unless the Injury or Sickness starts after the Covered Person has been free of medical care for that condition for 12 consecutive months ending on or after the Covered Person's effective date of benefit increase.

6) The following in the **Pre-Existing Conditions Limitation** provision is deleted in its entirety:

Pre-existing Condition means any Injury or Sickness for which medical care is received by the Covered Person:

1) within the 12 consecutive months prior to the date the Covered Person's insurance starts; or
2) within the 12 consecutive months prior to the effective date of the Covered Person's increase in coverage.

It is replaced by the following:

Pre-existing Condition means any Injury or Sickness for which medical care is received by the Covered Person:

1) within the 6 consecutive months prior to the date the Covered Person's insurance starts; or
2) within the 6 consecutive months prior to the effective date of the Covered Person's increase in coverage.

For Texas residents, the Certificate is amended as stated below:

1) The following **Policy Interpretation** provision is deleted in its entirety:

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, as amended (ERISA).

2) The following **Important Notice** provision is added in its entirety:

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-523-2233

You may also write to The Hartford at:

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

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

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
web: http://www.tdi.texas.gov
email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Hartford's para informacion o para someter una queja al:

1-800-523-2233

Usted tambien puede escribir a The Hartford:

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

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
web: http://www.tdi.texas.gov
email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

For Utah residents, the Certificate is amended as stated below.

1) If Your Employer has a Utah situs and is part of an out-of-state trust, the following applies:

   a) The provision titled **Misstatement of Age** is deleted in its entirety and replaced by the following:

      Misstatement of Age or Gender: If the age or gender of a Covered Person has been misstated the amount payable under The Policy is what the premium paid would have purchased if the age or gender had been stated correctly.

   b) The provision titled **Legal Actions** is deleted in its entirety and replaced by the following:

      Legal Actions: No legal action may start more than 3 years after the time proof of loss is required to be given. Unless by verified complaint it is alleged that prejudice to the complainant will arise from a delay in bringing suit against Us, which prejudice is other than the delay itself, no action may be brought against Us to compel payment under The Policy until the earliest of:
      1) 60 days after proof of loss has been furnished as required by The Policy;
      2) waiver by Us of proof of loss; or
      3) Our denial of full payment of the claim.

2) If Your Employer's plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provision is added to Your Certificate:

Newborn and Adopted Child Coverage Benefit

The Policy covers Medicare Eligible Children as follows:
1) a newly born children from birth; and
2) an Adopted Child starting from the:
   a) moment of birth, if placement for adoption occurs within 30 days of the child's birth; or
   b) date of placement, if placement for adoption occurs 30 days or more after the child's birth.

To the extent not covered by Medicare, The Policy covers expenses Incurred for a newly born and an Adopted Child from the date stated above for:
1) any Injury or Sickness covered by The Policy; and
2) the necessary care and treatment of medically diagnosed:
   a) congenital defects;
   b) birth abnormalities; and
   c) prematurity.

The coverage under this provision is not subject to any Pre-Existing Conditions limitation of The Policy.

Adopted Child, as used in this provision, means in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years of age as of the date of the adoption or placement for adoption.

If payment of a specific premium is required to provide coverage for a child, You must enroll:
1) a newly born child within 30 days after the date of birth of the child; or
2) an adopted child within 30 days after the date of placement of adoption.

If payment of a specific premium is not required to provide coverage for a child You must enroll the newly born child or the adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

Termination: Coverage under this benefit terminates under the same terms and conditions as stated in the Certificate for Dependent coverage. In addition coverage of an Adopted Child terminates if:
1) the placement is disrupted prior to legal adoption; and

2) the child is removed from placement; or
3) if the child is removed from placement prior to being legally adopted.

This benefit is paid subject to the conditions, terms, limitations and exclusions otherwise applicable to The Policy's Medicare Part A and Medicare Part B Benefits.

For Vermont residents, the Certificate is amended as stated below:

1) The Policy provides parties to a civil union and their Medicare Eligible Dependent Children with identical benefits, rights and protections as those afforded to married Spouses and their Medicare Eligible Dependent Children.

2) The following from the **Exclusions** provision is deleted in its entirety:

13) health services and associated expenses for sex transformation operations;

3) The following **Policy Interpretation** provision is deleted in its entirety:

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, as amended (ERISA).

For Virginia residents, the Certificate is amended as stated below:

1) The following is deleted from the **Spouse** provision in its entirety:

Spouse also includes any individual who is Your partner to:
1) a civil union;
2) a registered domestic partnership; or
3) another relationship allowed by state law.

Spouse will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You and Your partner will continue to be considered affidavit domestic partners provided You and Your Partner continue to meet the requirements described in the domestic partner affidavit.

2) The following **Other Eligible Individual** provision is added in its entirety:

Other Eligible Individual means any individual who is Your partner to:
1) a registered domestic partnership; or
2) another relationship allowed by state law.

Other Eligible Individual will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You and Your partner will continue to be considered affidavit domestic partners provided You and Your partner continue to meet the requirements described in the domestic partner affidavit.

Other Eligible Individual does not include any person who is insured as a Retiree.

3) Wherever the word "Spouse" appears in the Certificate, "or Other Eligible Individual" will also appear.

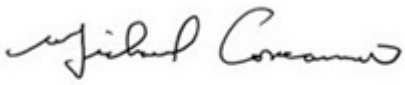
For West Virginia residents, the Certificate is amended to include the following notice, if not already part of the Certificate:

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

In all other respects the Certificate remains the same.

Signed for Hartford Life and Accident Insurance Company

Lisa Levin, *Secretary*



Michael Concannon, *President*

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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

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

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

1. **Plan Name**

   Group Retiree Insurance Plan® for retirees of CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN

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2. **Plan Number**

   Group Retiree Insurance - 501

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3. **Employer/Plan Sponsor**

   CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN
   2020 Jump Brook Road, PO Box 383
   Grand Gorge, NEW YORK 12434

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4. **Employer Identification Number**

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Retiree Insurance coverage.

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6. **Plan Administrator**

   CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN
   2020 Jump Brook Road, PO Box 383
   Grand Gorge, NEW YORK 12434

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

For the Plan

CATSKILL AREA SCHOOLS EMPLOYEE BENEFIT PLAN
2020 Jump Brook Road, PO Box 383
Grand Gorge, NEW YORK 12434

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** The Employer pays the premium for the insurance, but may allocate part of the cost to the retiree, or the retiree may pay the entire premium. The Employer determines the portion of the cost to be paid by the retiree. 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 Calendar 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.

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.

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

The Plan Described in this Booklet is Insured by the

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