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: City of Reno
Policy Number: TBD
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

Terence Shields, *Secretary* Michael Concannon, *Executive Vice 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.

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.

TABLE OF CONTENTS

SCHEDULE

ELIGIBLE CLASSES FOR COVERAGE

Class	Description of Eligible Persons:
I	Retirees only who are entitled to Medicare benefits by reason of age (i.e. 65 years of age and over).
II	Retirees, and their Medicare Eligible Dependents, entitled to Medicare by reason of age (i.e. 65 years of age and over).
III	Retirees under age 65 are not eligible for coverage, but they may enroll their Medicare Eligible Dependents entitled to Medicare by reason of age (i.e. 65 years of age and over).
IV	A widow or widower who is entitled to Medicare benefits by reason of age (i.e. 65 years of age and over) whose deceased Spouse was an active Employee/Retiree of the Policyholder.

BENEFIT DEDUCTIBLES, MAXIMUMS AND COINSURANCE	
Calendar Year Policy Deductible:	$500 Applies to Medicare Part B
Out-of-Pocket Expense Maximum for Medicare Part A and Medicare Part B:	$1,000 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* – Policy Coinsurance} 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* – Policy 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.
Hospital Confinement Benefit			
91st through 150th Day: *Medicare Part A Coinsurance* – Policy 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 Days 90 - 365 after the Lifetime Reserve Period:	$0	100% of the charges Incurred.	0% of the the charges Incurred.
Skilled Nursing Facility Confinement Benefit			
	MEDICARE PAYS	**WE PAY**	**COVERED PERSON PAYS**
Days 1 – 20	All Medicare Approved Amounts	$0	Amounts not paid by Medicare.
21st Through 100th Day – Policy Coinsurance 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* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Specialist Services Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Outpatient Hospital Services and Ambulatory Surgical Care Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Outpatient Diagnostic and Radiology Services Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Outpatient Mental Health and Substance Abuse Services Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible

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**
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Emergency Care Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $50 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Urgent Care Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
Ambulance Services Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining 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**
Durable Medical Equipment and Prosthetics Benefit			
Medicare Part B *Deductible* – Policy Coinsurance Coverage:	All but $183	0% of the remaining Medicare Part B Deductible.	100% of the remaining Medicare Part B Deductible
Medicare Part B *Coinsurance* – Policy Copayment Coverage:	Generally 80% of Medicare Approved Amounts.	100% of the remaining Medicare Part B Coinsurance, if any, after the Covered Person's payment.	Lesser of: 1) $10 Policy Copayment; or 2) the remaining Medicare Part B Coinsurance.
MEDICARE PART B EXCESS EXPENSE BENEFIT			
	$0	100%	100%

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.

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**
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:	80% 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. However, Inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

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

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 A Deductible and Medicare Part A Coinsurance apply to the calendar year policy deductible. 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.

Change in Family Status means one of the following events:

1) You get married;
2) You and Your Spouse divorce or legally terminate Your relationship;
3) Your Spouse dies;
4) Your Spouse is no longer eligible for Medicare;
5) Your Spouse is no longer employed, which results in a loss of group health insurance; or
6) Your Spouse becomes eligible for 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 Medicare Part A 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, 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 services:

1) to treat, evaluate or stabilize an emergency medical condition that requires immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb; and
2) rendered by a provider qualified to furnish emergency services.

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 an institution which:

1) is approved by Medicare and has agreed to participate in Medicare;
2) operates pursuant to law;
3) primarily and continuously provides medical care and treatment on an Inpatient basis for sick and injured persons at the patient's expense;
4) operates medical, diagnostic and major surgical facilities:
    a) on its premises; or
    b) in facilities available to the institution on a prearranged basis;
5) operates under the supervision of a staff of Physicians; and
6) provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof that is used primarily as:

1) a nursing home, convalescent home, or Skilled Nursing Facility;
2) a place for rest, custodial, educational or rehabilitative care;
3) a place for the aged;
4) a place for treatment of alcoholism or drug addiction; or
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.

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 request:
1) in writing;
2) by telephone;
3) by e-mail; or
4) through the Policyholder's website;

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 later 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:

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.

To enroll for Your Dependents' coverage, You must enroll for Retiree coverage under The Policy or, as applicable, under the Policyholder's employee health insurance policy.

If You do not enroll for Your coverage and/or Your Dependents' coverage within 31 days after becoming eligible under The Policy and later choose to enroll, You may only enroll for Your coverage and/or Your Dependents' coverage:
1) during an Annual Enrollment Period or any additional enrollment event designated by the Policyholder; or
2) within 31 days of the date You have a Change in Family Status.

The dates of the Annual Enrollment Period are shown in the Schedule.

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 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, 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 are age 65 or older and have enrolled on or before that date;
2) the date You become eligible for Dependent coverage if You are under age 65;
3) If You are age 65 or older, the date You enroll, if You do so within 31days from the date You are eligible for Dependent coverage;

4) If You are under age 65, the dateYou enroll Your Dependents, 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 date You remarry or execute a domestic partner affidavit.

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 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.

7) the date Your child no longer meets the definition of a Medicare Eligible Dependent Child;

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 paid any Policy Copayment required under a benefit provision;
6) the Covered Person has not exhausted any applicable benefit maximum;
7) the Covered Person has not exhausted the Lifetime Policy Maximum Benefit; and
8) 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 Deductible* 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.

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, the Covered Person pays the lesser of:

1) the Policy Copayment; or
2) the remaining Medicare Part B Coinsurance;

shown in the Schedule.

We pay Our percentage, shown in the Schedule, of the remaining Medicare Part B Coinsurance, if any.

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) any territory or protectorate of the United States in which Medicare is not used or accepted.

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 ordered by a Physician; and
3) one prostate screening each Calendar Year for the early detection of prostate cancer for men over 50 years of age. The screening may be performed by any qualified medical professional, including an urologist, an internist, a general practitioner, a doctor of osteopathy, a nurse practitioner or a physician assistant. The screening must include at least the following:
    a) a prostate-specific antigen (PSA) blood test; or
    b) a digital rectal examination.

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 6 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 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 6 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 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.

Exclusions: The Policy does not cover:

1) any expense that is:
    a) not a Medicare eligible expense; except those benefits that are included in the Additional Plan Benefits section of Your Certificate;

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) elective or cosmetic surgery;
10) telephone-medicine, e-mail-medicine, internet connection-medicine and telemedicine;
11) orthognathic surgery;
12) surrogate parenting;
13) health services and associated expenses for sex transformation operations;
14) services and supplies paid for through a legal action or settlement;
15) any expense in connection with an Injury or Sickness for which benefits are provided under workers' compensation, occupational disease, employers' liability or similar law;
16) any expense in connection with an Injury or Sickness which is due to war or act of war, whether declared or not;
17) 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; or
18) 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 start:

1) until 60 days after proof of loss has been given; or
2) more than 3 years after the time proof of loss is required to be given.

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.

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).

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

Time of Payment of Claims: Benefits payable under this Certificate will be paid within 30 days after Our receipt of due written Proof of Loss.

Payment of Claims: 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 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 Overpayment Recovery from a Provider provision.

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 within 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
by having the amounts reduce or offset against any future benefits payable to the provider until full reimbursement is made.