

YOUR BENEFIT PLAN



CALIFORNIA SCHOOLS EMPLOYEE BENEFITS ORGANIZATION

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State Notices

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

The insurance carrier for the Policy is:

**The Hartford
Group Benefits Division,
Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233**

The Claims Administrator for the Policy is:

**WebTPA
P.O. Box 99906
Grapevine, TX 76099
1-866-547-4205**

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

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

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

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

NOTICES

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

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

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

- **Illinois: For Your Questions and Complaints:**
Illinois Department of Insurance
320 West Washington Street
Consumer Services Station
Springfield, Illinois 62767
Consumer Assistance: 1(866) 445-5364
Officer of Consumer Health Insurance: 1(877) 527-9431
Web Address: <http://insurance.illinois.gov/>
- **Pennsylvania:** Hartford Life and Accident Insurance Company complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex including sex stereotypes and gender identity. Hartford Life and Accident Insurance Company does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.
- **Texas:** In addition to the insurance coverage, We may offer Noninsurance Benefits and Services to You. Your access to these benefits and services is included with Your insurance coverage and does not require enrollment or premium payment. You should contact the Policyholder for more information on the services available on their plan.

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

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

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

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

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

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

- **Texas:**

Have a complaint or need help?

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

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

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

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

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

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

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

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

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

- **Wisconsin: For Your Questions and Complaints:**

To request a Complaint Form:

Office of the Commissioner of Insurance

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

1(800) 236-8517 (outside of Madison)

1(608) 266-0103 (in Madison)

- **Virginia: For Your Questions and Complaints:**

State Corporation Commission

Life and Health Division

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

CERTIFICATE FACE PAGE

- **California:** This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.
- **Maine:** If You have a Medicare supplement policy or major medical policy, this coverage may be more than You need. For information call the Bureau of Insurance at (800) 300-5000.
- **Maryland:** The group insurance Policy providing coverage under the Certificate may have been issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

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

- **Massachusetts:**



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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

- **New Hampshire:**

This is a Limited Policy - Read it Carefully

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

DEFINITIONS

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

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

TERMINATION OF COVERAGE

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

REINSTATEMENT OF COVERAGE

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

CONTINUATION AND EXTENSION OF COVERAGE

- New Hampshire: The following **Extension of Coverage While Disabled** provision is added to the **Continuation and Extension of Coverage** section:
Extension of Coverage While Disabled
If You are Disabled when coverage would otherwise terminate because You are no longer eligible for insurance or are no longer in an Eligible Class, or the Policy terminates, coverage will be extended for 90 days after it would otherwise terminate, while Disability continues. Extended coverage will be limited to Hospital Confinements commencing for the Injury or Illness causing the Disability.

GENERAL LIMITATIONS & EXCLUSIONS

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

CLAIM PROVISIONS

- Maine: The initial notice of claim time frame, described in the **Notice of Claim** provision, is 30 days.
- New Hampshire: The initial proof of loss time frame, described in the **Proof of Loss** provision, is 90 days.
- North Carolina: The initial proof of loss time frame, described in the **Proof of Loss** provision, is 180 days.
- Minnesota: The payment time frame, described in the **Time of Payment of Claims** provision, is immediately upon Our receipt of due Proof of Loss.
- Minnesota: The **Payment of Claims** provision is amended to make any benefits unpaid at the time of Your death payable to Your designated beneficiary(ies); or if none, then to Your estate.
- Colorado: The **Claim Appeal** provision includes the following:
If a claim for benefits has been denied in whole or in part and all administrative remedies have been exhausted, the claimant is entitled to have the claim reviewed de novo (from the beginning) in any court with jurisdiction and to a trial by jury.

GENERAL PROVISIONS

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

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

GROUP CRITICAL ILLNESS (SPECIFIED DISEASE) INSURANCE OUTLINE OF COVERAGE

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.

NOTICE: Read this outline of coverage carefully. It may not be identical to the outline of coverage provided at the time You enrolled for insurance, and the insurance You originally enrolled for may not have been issued.

NOTICE TO BUYER: This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

CRITICAL ILLNESS (SPECIFIED DISEASE) COVERAGE – OUTLINE OF COVERAGE

THE POLICY PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless You have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance (https://www.naic.org/documents/prod_serv_consumer_guide_cancer.pdf) to review the possible limits on benefits in this type of coverage.

Read Your Certificate Carefully – This outline of coverage provides a very brief description of the important features of this insurance. This outline of coverage is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of You, the Policyholder and the insurance company. It is, therefore, important that You **READ YOUR CERTIFICATE CAREFULLY!**

Critical illness coverage is designed to provide, to persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of diagnosis of specified diseases. Coverage is **NOT** provided for basic hospital, basic medical-surgical or major medical expenses.

Benefits provided are supplemental and are not intended to cover all medical expenses. The Policy does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

THE KEY DEFINITIONS SECTION DEFINES THE CRITICAL ILLNESSES INCLUDING WHAT IS COVERED AND WHAT IS EXCLUDED FROM CONSIDERATION AS A CRITICAL ILLNESS. READ THE DEFINITION OF EACH CRITICAL ILLNESS CAREFULLY TO DETERMINE WHAT CONDITIONS ARE INCLUDED AND/OR EXCLUDED.

NOT ALL CRITICAL ILLNESSES ARE PAID AT THE SAME BENEFIT LEVEL. THE CERTIFICATE PAYS A REDUCED AMOUNT FOR CERTAIN BENEFITS AS SOME CRITICAL ILLNESSES ARE PAID AT A LESSER LEVEL THAN OTHER CRITICAL ILLNESSES. READ THE CRITICAL ILLNESS BENEFITS AND THE ADDITIONAL BENEFIT(S) SECTIONS CAREFULLY TO DETERMINE BENEFIT AMOUNTS. WITH SPECIFIC REGARD TO THE FOLLOWING TYPES OF CANCER, A LIMITED BENEFIT IS PAYABLE FOR:

- 1) early prostate cancer classified as AJCC Stage T1N0M0;
- 2) lymphoma classified as stage I or lower and asymptomatic myeloma;
- 3) chronic myeloid leukemia classified as chronic phase;
- 4) chronic lymphocytic leukemia classified as Rai Stage 0 or Binet Stage A;
- 5) Other Skin Malignancies classified as AJCC Stage III or lower such as: basal cell carcinoma, cutaneous lymphoma, merkel cell carcinoma and squamous cell carcinoma; and
- 6) malignant melanoma that has been classified as AJCC Stage I or lower.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* ("Medicare & You" handbook) available through www.medicare.gov/publications or from Us.

This outline of coverage provides a very brief summary of the terms and conditions of the Certificate. For a complete description refer to the appropriate section of the Certificate, available from the Policyholder. The 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 Certificate or refers to a specific provision contained within the Certificate. A person is not entitled to insurance because they received this outline of coverage. A person is only entitled to insurance if they are eligible and insured in accordance with the terms of the Policy. This outline of coverage was published on November 13, 2023.

POLICY INFORMATION

Policyholder: CALIFORNIA SCHOOLS EMPLOYEE BENEFITS ORGANIZATION
 Policy Number: VCI-874079
 Situs/Issue State: California
 Policy Effective Date: January 1, 2024
 Policy Anniversary: January 1

ELIGIBLE CLASS(ES)

All Full-time Active Employees

COVERAGE ELECTION

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

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

COVERAGE AMOUNT(S)

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

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

CRITICAL ILLNESS BENEFITS

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

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

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

Critical Illness: **Initial Occurrence Benefit Amount:** **Reoccurrence Benefit Amount:**

CANCER & BENIGN TUMOR CATEGORY

Cancer (Invasive)	100%	100%
Carcinoma in Situ (Non-Invasive)	25%	100%
Specified Skin Cancer	\$250	None
Bone Marrow Failure	25%	None
Benign Brain or Spinal Cord (Intradural) Tumor		
• Early Diagnosis	10%	None
• Advanced Diagnosis	100%	None

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

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

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

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
INFECTIOUS CONDITIONS CATEGORY		
Severe Infectious Disease (Requiring Hospitalization)	25%	None

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

Critical Illness: **Initial Occurrence Benefit Amount:** **Reoccurrence Benefit Amount:**

CHILD CONDITIONS CATEGORY

Cerebral Palsy		
• Early Diagnosis	10%	None
• Advanced Diagnosis	100%	None
Congenital Heart Defect	100%	None
Congenital Metabolic Disorder	100%	None
Genetic Disorder	100%	None
Structural Congenital Defect	100%	None

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

Policy Benefit Maximum. 500% – The Policy Benefit Maximum is a percentage of the applicable Coverage Amount in effect for a Covered Person at the time of Diagnosis of a Critical Illness. A Covered Person may receive multiple Critical Illness benefit payments under the Policy until the maximum is reached.

ADDITIONAL BENEFIT(S)

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

Benefit:	Benefit Amount:	Benefit Maximum:
Health Screening	\$50	Once per Policy Year

GENERAL LIMITATIONS & EXCLUSIONS

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

Unless otherwise stated in the Certificate, We will not pay benefits for any Critical Illness included in the Policy if a Covered Person was Diagnosed with such illness or condition prior to the Covered Person’s effective date under the Policy.

Initial Occurrence Benefit Separation Period. Once a Critical Illness is Diagnosed for which a benefit is payable for a Covered Person, in order for an Initial Occurrence Benefit to be payable for any other Critical Illness, an Initial Occurrence Benefit Separation Period of 30 days must be satisfied. This limitation is fully described in the Certificate.

Reoccurrence Benefit Separation Period. Once a Critical Illness is Diagnosed for which a benefit is payable for a Covered Person, in order for a Reoccurrence Benefit to be payable for that same Critical Illness, a Reoccurrence Benefit Separation Period of 180 days must be satisfied.

Policy Benefit Maximum. Each Covered Person may receive multiple payments for Critical Illness Benefits under this Certificate until the Policy Benefit Maximum shown in the Benefit Schedule is reached. Any payments received by a Covered Person for any Additional Benefit(s) do not count toward this maximum. This limitation is fully described in the Certificate.

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

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

- 5) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate; or
- 6) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer.

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

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

KEY DEFINITIONS

A summary of some of the key definitions of the Policy is provided below. Please refer to the Definitions section of the Certificate for a complete listing of the definitions applicable to this coverage.

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

For purposes of this Certificate, cancer does not include: Carcinoma in Situ (Non-Invasive); Specified Skin Cancer; Premalignant Conditions; or other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential. Additional Requirements to receive this benefit are fully described in the Certificate.

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

Carcinoma in situ does not include: Specified Skin Cancer; Premalignant Conditions; or other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential. Additional Requirements to receive this benefit are fully described in the Certificate.

Coronary Artery Disease means the narrowing or blockage of at least 50% of one or more coronary arteries. Additional Requirements to receive this benefit are fully described in the Certificate.

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

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

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

End Stage Renal Disease (ESRD) means the chronic and irreversible failure of both kidneys to function. For purposes of this Certificate, end stage renal disease (ESRD) does not include kidney failure caused by a traumatic event or surgical trauma. Additional Requirements to receive this benefit are fully described in the Certificate.

Heart Attack (Myocardial Infarction) means a condition that occurs when a severe and sudden loss of adequate blood supply to part of the heart muscle causes damage to the heart muscle. For purposes of this Certificate, heart attack

(myocardial infarction) includes: ST-Segment Elevation Myocardial Infarction (STEMI); and Non-ST Segment Elevation Myocardial Infarction (NSTEMI).

Heart attack (myocardial infarction) does not include: other acute coronary syndromes (including but not limited to unstable angina or coronary artery spasm); any other disease or Injury involving the cardiovascular system; any established (old) myocardial infarction; any heart attack that occurs during a Surgical Procedure or any other clinical procedure; any heart attack that is the result of Substance Use Disorder; or cardiac arrest not caused by a myocardial infarction, such as Sudden Cardiac Arrest. Additional Requirements to receive this benefit are fully described in the Certificate.

Major Organ Failure means the irreversible failure due to end-stage organ disease of the heart, liver, lung, pancreas, small intestine or large intestine. Major organ failure does not include the failure of any: major organ as a direct result of life-threatening cancer; or other organs, parts of organs, tissues or cells not listed in this definition.

Mild Stroke means a Stroke with neurological deficits that is categorized: with a score of 1 through 4 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event; with a score of 1 or 2 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or as a mild Stroke on any other stroke assessment scale administered in accordance with current medically accepted standards. Mild stroke does not include Transient Ischemic Attack (TIA).

Moderate Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized: with a score of 5 through 14 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event; with a score of 3 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or as a moderate stroke on any other stroke assessment scale administered in accordance with current medically accepted standards. Moderate stroke does not include Transient Ischemic Attack (TIA).

Non-ST Segment Elevation Myocardial Infarction (NSTEMI) means a type of myocardial infarction: in which a coronary artery is only partially or temporarily blocked; which appears in new and serial characteristic electrocardiographic (EKG) changes not inclusive of ST segment elevation; and following which elevation of cardiac enzymes or troponins can be detected in the blood above standard laboratory levels of normal. Non-ST segment elevation myocardial infarction (NSTEMI) includes a subendocardial infarction, also known as a “non-Q-wave heart attack.”

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

Severe Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized: with a score of 15 or greater on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event; with a score of 4 or greater on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or as a severe or very severe Stroke on any other stroke assessment scale administered in accordance with current medically accepted standards. Severe stroke does not include Transient Ischemic Attack (TIA).

Specified Skin Cancer means, for purposes of this coverage: Other Skin Malignancies classified as AJCC Stage I or lower; or malignant melanoma classified as AJCC Stage 0 or in situ. Additional Requirements to receive this benefit are fully described in the Certificate.

Stroke means an acute cerebral vascular incident that occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen or nutrients, caused by any of the following: hemorrhage; thrombus; or embolus from an extra-cranial source; that results in neurological impairment or deficit. Stroke includes: Mild Stroke; Moderate Stroke; and Severe Stroke. Stroke does not include: ischemic disorders of the vestibular system; brain Injury related to trauma or infection; or brain Injury associated to hypoxia/anoxia or hypotension. Additional Requirements to receive this benefit are fully described in the Certificate.

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

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

You, Your, Primary Insured means an Employee who is currently insured under the Policy and this Certificate.

ELIGIBILITY

To be eligible for coverage, an Employee must be performing the normal duties of his/her regular job for the Policyholder in the usual way for 20 or more hours each week and be receiving compensation from the Policyholder for work performed.

Your Dependent(s) must be able to perform normal and customary activities and not be confined (at home, in a hospital or in any other medical facility) to be eligible for coverage. In addition, Dependent Child(ren) must be under age 26 to be eligible for coverage unless otherwise allowed by the Policy.

Each person must be insured by an individual or policy or contract that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans to be eligible for insurance under the Policy.

The day on which an Employee or Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. Additional eligibility conditions may apply as described in the Certificate.

INITIAL ENROLLMENT

An Employee must enroll for coverage for the Employee and any Dependent(s) within 31 days following the day the Employee or Dependent(s) first become(s) eligible for coverage under the Policy. If an Employee does not elect coverage during the Employee's or Dependent's initial enrollment period, future enrollment may only occur as provided in the Changes in Coverage provision of the Certificate. Additional enrollment conditions may apply as described in the Certificate.

COVERAGE EFFECTIVE DATE (WHEN COVERAGE BEGINS)

Coverage will start on the later to occur of the:

- 1) first day of the month following the date an Employee or Dependent becomes eligible, if enrolled for coverage on or before that date; or
- 2) first day of the month following the date an Employee or Dependent is enrolled for coverage.

In no event will Dependent insurance become effective before an Employee becomes insured. The Coverage Effective Date for any Employee or Dependent is subject to the Deferred Coverage Effective Date provision of the Certificate. Additional eligibility conditions may apply as described in the Certificate.

FEATURE(S)

Partner Coverage. Any reference to "Spouse" includes any individual who is a partner to an Employee in a civil union or domestic partnership, or other relationship as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in the Employee's jurisdiction of residence.

Continuation of Coverage. You may be able to continue insurance for You and Your Dependent(s) in certain circumstances when You are no longer Actively at Work, with payment of premium and subject to certain conditions. The available continuation option(s) are described in the Certificate.

Extended Continuation. You or an insured Spouse, in certain circumstances, may continue coverage under the Policy when insurance would otherwise end under the Termination of Coverage provision, with payment of premium and subject to certain conditions. This provision is fully described in the Certificate.

TERMINATION OF COVERAGE (WHEN COVERAGE ENDS)

Coverage for You and any Dependent(s) will end on the last day of the month during which You are no longer eligible for insurance under any provision of the Policy. Coverage for a Dependent will also end on the last day of the month during which a Dependent no longer satisfies the definition of Spouse or Dependent Child(ren). Additional circumstances under which coverage will end are described in the Certificate. Termination of coverage has no effect on benefits payable for a Critical Illness that is Diagnosed or Treatment that is received while a Covered Person was insured under the Policy.

PREMIUMS

The premium rate structure for this insurance is comprised of attained age rates per \$1,000 dollars of insurance for each Covered Person, with specified age bands. You are responsible for the payment of premiums for insurance under the Policy, if You elect coverage. Payment of premium does not guarantee eligibility for insurance.

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Additional considerations for premium payment may apply when insurance is continued under any continuation option, as described in the Certificate. Premiums for this coverage are subject to change in accordance with the provisions of the Policy. Contact the Policyholder or Your benefits administrator for additional information on the current premium structure for the Policy.

HOW TO OBTAIN A COPY OF THE CERTIFICATE

To obtain a copy of the Certificate, first contact the Policyholder or Your benefits administrator. If You do not receive what You need, You may then contact Us at 1-800-523-2233 (toll-free).

ADMINISTRATION OF COVERAGE

Some services related to this coverage may be performed by Our third-party administrator(s). These arrangements in no way alter Our obligation(s) to You. Services will not be performed by third-party administrator(s) if prohibited through mutual agreement with the Policyholder.

GROUP CRITICAL ILLNESS (SPECIFIED DISEASE) INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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



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

Policyholder: CALIFORNIA SCHOOLS EMPLOYEE BENEFITS ORGANIZATION

Policy Number: VCI-874079

Policy Effective Date: January 1, 2024

Policy Anniversary: January 1

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

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

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

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

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

THE DEFINITIONS SECTION DEFINES THE CRITICAL ILLNESSES INCLUDING WHAT IS COVERED AND WHAT IS EXCLUDED FROM CONSIDERATION AS A CRITICAL ILLNESS. READ THE DEFINITION OF EACH CRITICAL ILLNESS CAREFULLY TO DETERMINE WHAT CONDITIONS ARE INCLUDED AND/OR EXCLUDED.

NOT ALL CRITICAL ILLNESSES ARE PAID AT THE SAME BENEFIT LEVEL. THIS CERTIFICATE PAYS A REDUCED AMOUNT FOR CERTAIN BENEFITS AS SOME CRITICAL ILLNESSES ARE PAID AT A LESSER LEVEL THAN OTHER CRITICAL ILLNESSES. READ THE BENEFIT SCHEDULE CAREFULLY TO DETERMINE BENEFIT AMOUNTS. WITH SPECIFIC REGARD TO THE FOLLOWING TYPES OF CANCER, A LIMITED BENEFIT IS PAYABLE FOR:

- 1) early prostate cancer classified as AJCC Stage T1N0M0;
- 2) lymphoma classified as stage I or lower and asymptomatic myeloma;
- 3) chronic myeloid leukemia classified as chronic phase;
- 4) chronic lymphocytic leukemia classified as Rai Stage 0 or Binet Stage A;
- 5) Other Skin Malignancies classified as AJCC Stage III or lower such as: basal cell carcinoma, cutaneous lymphoma, merkel cell carcinoma and squamous cell carcinoma; and
- 6) malignant melanoma that has been classified as AJCC Stage I or lower.

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

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

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

YOUR RIGHT TO RETURN THE CERTIFICATE: YOU HAVE THE RIGHT TO RETURN THE CERTIFICATE WITHIN 30 DAYS AFTER ITS RECEIPT VIA REGULAR MAIL OR OTHER DELIVERY METHOD AND TO HAVE THE FULL PREMIUM REFUNDED. 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 WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED 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 contained herein.

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BENEFIT SCHEDULE

Eligible Class(es)

All Full-time Active Employees

Coverage Election

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

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

Coverage Amount(s)

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

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

Initial Occurrence Benefit Separation Period

30 days

Reoccurrence Benefit Separation Period

180 days

Policy Benefit Maximum

500%

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

CRITICAL ILLNESS BENEFITS TABLE

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

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

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

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
CANCER & BENIGN TUMOR CATEGORY		
Cancer (Invasive)	100%	100%
Carcinoma in Situ (Non-Invasive)	25%	100%
Specified Skin Cancer	\$250	None
Bone Marrow Failure	25%	None
Benign Brain or Spinal Cord (Intradural) Tumor		
• Early Diagnosis	10%	None
• Advanced Diagnosis	100%	None

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

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

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

Critical Illness:	Initial Occurrence Benefit Amount:	Reoccurrence Benefit Amount:
INFECTIOUS CONDITIONS CATEGORY		
Severe Infectious Disease (Requiring Hospitalization)	25%	None

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

Critical Illness: **Initial Occurrence Benefit Amount:** **Reoccurrence Benefit Amount:**

CHILD CONDITIONS CATEGORY

Cerebral Palsy		
• Early Diagnosis	10%	None
• Advanced Diagnosis	100%	None
Congenital Heart Defect	100%	None
Congenital Metabolic Disorder	100%	None
Genetic Disorder	100%	None
Structural Congenital Defect	100%	None

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

ADDITIONAL BENEFIT(S) TABLE

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

Benefit:	Benefit Amount:	Benefit Maximum:
Health Screening	\$50	Once per Policy Year

DEFINITIONS

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

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

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

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

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

- 1) performing all the regular duties of their job for the Policyholder in the usual way for 20 or more hours each week; and
- 2) receiving compensation from the Policyholder for work performed.

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

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

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

Aneurysm means a balloon-like bulge or weakening in the walls of an artery. Aneurysm includes:

- 1) Abdominal Aortic Aneurysm;
- 2) Thoracic Aortic Aneurysm; and
- 3) Other Dissecting or Ruptured Aneurysm.

Aneurysm does not include an aneurysm caused by trauma.

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

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

Benign Brain or Spinal Cord (Intradural) Tumor means a non-cancerous tumor that is located and originates in the:

- 1) brain, cranial nerves or on the meninges that protect the brain; or
- 2) spinal cord (intradural).

A benign brain or spinal cord (intradural) tumor does not include:

- 1) any tumor resulting from neurofibromatosis, tuberous sclerosis or Von Hippel-Lindau disease if Diagnosed prior to a Covered Person's effective date of coverage under the Policy;
- 2) tumors of the skull, vertebrae or peripheral nerves;
- 3) pituitary adenomas less than 1 cm; or
- 4) angiomas or aneurysms.

Bone Marrow Failure means the irreversible failure of the bone marrow's ability to produce enough healthy blood cells to maintain the body's needs, for which a Physician recommends an autologous or allogeneic transplant of bone marrow or stem cells for Treatment of the condition.

Cancer (Invasive) means a disease identified by the presence of malignant cells or a malignant tumor, characterized by the abnormal and uncontrolled growth and spread of invasive malignant cells or an invasive malignant tumor to tissue beyond the tissue of origin. Cancer includes (but is not limited to) the following:

- 1) lymphoma classified as stage II or higher, symptomatic myeloma and sarcoma;
- 2) acute forms of leukemia, chronic myeloid leukemia classified as accelerated or blast phase, or chronic lymphocytic leukemia classified as Rai Stage I or Binet Stage B or greater;
- 3) any cancer of the breast, including those classified as stage 0 or in situ;
- 4) Other Skin Malignancy classified as AJCC Stage IV or greater; and
- 5) malignant melanoma classified as AJCC Stage II or greater.

Cancer does not include:

- 1) Carcinoma in Situ (Non-Invasive);
- 2) Specified Skin Cancer;
- 3) Premalignant Conditions; or
- 4) other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential.

Carcinoma in Situ (Non-Invasive) means a group of abnormal cells that have not yet become invasive and are confined to the tissue of origin without having invaded neighboring tissue or regional lymph nodes, typically classified as AJCC Stage 0 or in situ cancer. Carcinoma in situ includes (but is not limited to) the following:

- 1) early prostate cancer classified as AJCC Stage T1N0M0;
- 2) lymphoma classified as stage I or lower and asymptomatic myeloma;
- 3) chronic myeloid leukemia classified as chronic phase;
- 4) chronic lymphocytic leukemia classified as Rai Stage 0 or Binet Stage A;
- 5) Other Skin Malignancy classified as AJCC Stage II or III; and
- 6) malignant melanoma that has been classified as AJCC Stage I.

Carcinoma in situ does not include:

- 1) Specified Skin Cancer;
- 2) Premalignant Conditions; or
- 3) other benign or precancerous conditions, lesions or polyps, or conditions having borderline malignancy or malignant potential.

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

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

Other conditions similar to cerebral palsy such as:

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

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

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

Change in Family Status means one of the following events:

- 1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
- 2) You and Your Spouse divorce or legally terminate Your relationship;
- 3) Your Spouse dies;
- 4) You acquire a child who satisfies the definition of Dependent Child;

- 5) Your child no longer satisfies the definition of a Dependent Child or dies;
- 6) Your Spouse is no longer employed, which results in a loss of insurance sponsored by the Spouse's employer for You or any Dependent(s); or
- 7) You change work classification from part-time to full-time or from full-time to part-time.

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

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

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

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

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

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

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

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

Confined Elsewhere means a Dependent is unable to leave their home or other place of residence without assistance.

Congenital Anomalies means a structural or functional defect that existed prior to birth whether identified prenatally, at birth, or later in infancy. Congenital anomalies include but are not limited to the conditions of: cleft lip; cleft palate; defects of metabolism; sixth toes or fingers; webbed fingers or toes; or other conditions that are medically diagnosed to be congenital anomalies.

Congenital Heart Defect means any of the following:

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

Congenital Metabolic Disorder means any of the following:

- 1) Gaucher's disease types 2 and 3;
- 2) glutaric acidemia type 1;
- 3) glycogen storage disease type II (also known as Pompe disease) and IV (also known as Andersen Disease);
- 4) infantile or juvenile GM2 gangliosidoses, including:
 - a) hexosaminidase activator deficiency;
 - b) Sandhoff disease; or
 - c) Tay-Sachs disease;
- 5) Lesch Nyhan syndrome;

- 6) Niemann-Pick disease; or
- 7) Zellweger syndrome (excluding other Zellweger spectrum disorders).

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

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

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

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

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

Dementia means a permanent, progressive neurological condition that results in memory impairment and cognitive decline. Dementia includes:

- 1) Alzheimer's disease;
- 2) corticobasal degeneration;
- 3) dementia with Lewy bodies;
- 4) frontotemporal dementia;
- 5) Parkinson's disease dementia;
- 6) primary progressive aphasia;
- 7) progressive supranuclear palsy; or
- 8) rapidly progressive dementia such as Creutzfeldt-Jakob disease.

Dementia does not include:

- 1) any form of dementia that is a mental condition, such as schizophrenia or psychoses;
- 2) any form of Parkinson's disease other than Parkinson's disease dementia;
- 3) reversible dementias, such as those caused by thyroid abnormalities, other hormonal abnormalities or vitamin deficiencies; or
- 4) substance-induced conditions.

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

Dependent Child(ren) means:

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

who is/are under 26 years of age.

If a child is age 26 or older and is:

- 1) incapable of self-sustaining employment because of a mental or physical disability;
- 2) chiefly dependent on the Employee or Spouse for financial support and maintenance;

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

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

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

Employee means a person who:

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

This definition does not include a person working for the Policyholder:

- 1) on a temporary, leased or seasonal basis;
- 2) as an independent contractor (including persons for whom income is reported on a 1099 form);
- 3) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
- 4) who resides outside the United States for a period in excess of 12 months, unless Written approval has been received from Us.

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

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

Genetic Disorder means any of the following:

- 1) cystic fibrosis;
- 2) infantile onset ascending spastic paralysis;
- 3) Down syndrome;
- 4) juvenile primary lateral sclerosis;
- 5) muscular dystrophy;
- 6) osteogenesis imperfecta (excluding type 1);
- 7) sickle cell anemia (excluding sickle cell trait);
- 8) spinal muscular atrophy types 0, 1, 2 and 3; or
- 9) vascular Ehlers-Danlos syndrome.

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

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

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

Heart Attack (Myocardial Infarction) means a condition that occurs when a severe and sudden loss of adequate blood supply to part of the heart muscle causes damage to the heart muscle. Heart attack (myocardial infarction) includes:

- 1) ST-Segment Elevation Myocardial Infarction (STEMI); and
- 2) Non-ST Segment Elevation Myocardial Infarction (NSTEMI).

Heart attack (myocardial infarction) does not include:

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

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

Hospital means an institution:

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

Hospital does not include:

- 1) convalescent homes, or convalescent, rest or nursing facilities;
- 2) facilities affording primarily custodial, educational or rehabilitative care; or
- 3) facilities primarily for care of the aged/elderly, care of persons with Substance Use Disorders, or care of persons with Mental Health Disorders.

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

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

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

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

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

Loss of Sight means permanent loss of sight in both eyes caused by an illness or disease:

- 1) with no realistic expectation of improvement; and
- 2) with best correction of either eye, visual acuity must be less than 6/60 (metric acuity) or 20/200 (Snellen chart or E chart acuity); or
- 3) the field of vision must be less than 20 degrees in both eyes.

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

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

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

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

Major organ failure does not include the failure of any:

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

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

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

Mental Health Disorder means any condition, disease or disorder recognized as a mental or nervous disorder in accordance with current medically accepted standards.

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

Mild Stroke means a Stroke with neurological deficits that is categorized:

- 1) with a score of 1 through 4 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event;

- 2) with a score of 1 or 2 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or
- 3) as a mild Stroke on any other stroke assessment scale administered in accordance with current medically accepted standards.

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

Moderate Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized:

- 1) with a score of 5 through 14 on the National Institutes of Health Stroke Scale (NIHSS) measured at least 24 hours after the initial onset of the Stroke event;
- 2) with a score of 3 on the Modified Rankin Scale (mRS) measured at least 90 days after the onset of the Stroke event; or
- 3) as a moderate stroke on any other stroke assessment scale administered in accordance with current medically accepted standards.

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

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

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

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

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

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

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

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

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

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

Parkinson’s disease does not include:

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

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

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

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

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

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

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

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

Physician means a person who is:

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

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

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

Premalignant Conditions means:

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

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

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

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

Severe Dengue means dengue hemorrhagic fever and dengue shock syndrome.

Severe Infectious Disease means any of the following severe infectious or contagious diseases:

- 1) anthrax;
- 2) Asian H5N1 (formally Highly Pathogenic Asian Avian Influenza A H5N1);
- 3) brucellosis;
- 4) cholera;
- 5) COVID-19 (formally SARS-CoV-2/2019-nCoV);
- 6) diphtheria;
- 7) Ebola virus disease;
- 8) encephalitis;
- 9) flesh-eating disease (formally necrotizing fasciitis);
- 10) hantavirus pulmonary syndrome;
- 11) histoplasmosis;
- 12) invasive pneumococcal disease (formally streptococcus pneumoniae);
- 13) leptospirosis;
- 14) mad cow disease (formally variant Creutzfeldt-Jakob disease (vCJD));

- 15) meningitis;
- 16) Middle East respiratory syndrome (formally MERS-CoV (MERS));
- 17) Mosquito-Borne Disease;
- 18) osteomyelitis;
- 19) polio (formally poliomyelitis);
- 20) rabies;
- 21) Reye's syndrome;
- 22) severe acute respiratory syndrome (formally SARS-CoV (SARS));
- 23) tetanus;
- 24) Tick-Borne Disease;
- 25) tuberculosis;
- 26) typhoid fever; and
- 27) whooping cough (formally pertussis).

A severe infectious disease does not include any condition:

- 1) not listed in this definition; or
- 2) listed in this definition for which a Covered Person is asymptomatic.

Severe Stroke means a Stroke resulting in one or more Permanent Neurological Deficits that is categorized:

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

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

Specified Skin Cancer means:

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

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

For CA residents, spouse includes any individual as defined under CA Family Code Section 297.

For residents of states other than CA, spouse includes any individual who is a partner to an Employee in a civil union or domestic partnership, or other relationship as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in the Employee's jurisdiction of residence, if:

- 1) an Employee provides evidence that the requirements of the jurisdiction in which they reside for the establishment of the relationship have been met;
- 2) an Employee submits a Written declaration of partnership signed by both parties; or
- 3) the Employee and their partner satisfy the Policyholder's requirements for such partnerships.

Stroke means an acute cerebral vascular incident that occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen or nutrients, caused by any of the following:

- 1) hemorrhage;
- 2) thrombus; or
- 3) embolus from an extra-cranial source;

that results in neurological impairment or deficit. Stroke includes:

- 1) Mild Stroke;
- 2) Moderate Stroke; and
- 3) Severe Stroke.

Stroke does not include:

- 1) ischemic disorders of the vestibular system;
- 2) brain Injury related to trauma or infection; or
- 3) brain Injury associated to hypoxia/anoxia or hypotension.

Structural Congenital Defect means any of the following:

- 1) anal atresia;
- 2) biliary atresia;
- 3) cleft lip or palate;
- 4) club foot;
- 5) diaphragmatic hernia;
- 6) gastroschisis;
- 7) Hirschsprung's disease;
- 8) omphalocele;
- 9) pyloric stenosis; or
- 10) spina bifida (excluding spina bifida occulta).

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

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

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

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

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

Sudden cardiac arrest does not include:

- 1) a Heart Attack (Myocardial Infarction); or
- 2) any sudden cardiac arrest that occurs during a Surgical Procedure or any other clinical procedure.

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

Thoracic Aortic Aneurysm means an Aneurysm located in the thoracic (upper) part of the aorta that is:

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

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

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

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person. For any Critical Illness included in the Cancer & Benign Tumor Category, following a declaration of Complete Remission/No Evidence of Disease by the primary treating Physician for a prior diagnosis of a Critical Illness, this definition does not include:

- 1) routine follow-up visits or assessments with a Physician or Medical Professional to verify whether or not the Critical Illness has returned; or
- 2) Maintenance Drug Therapy.

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

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

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

ELIGIBILITY & EFFECTIVE DATES

Eligibility for Coverage

An Employee will become eligible for coverage under the Policy on the later of:

- 1) the Policy Effective Date; or
- 2) the date they become a member of an Eligible Class.

A Dependent will become eligible for coverage under the Policy on the later of:

- 1) the date the Employee becomes insured under the Policy; or
- 2) the date You acquire the Dependent.

If more than one person within an immediate family unit is eligible for coverage under the Policy as an Employee of the Policyholder, then:

- 1) neither Employee may be covered as a Dependent of the other person; and
- 2) Dependent Child(ren) may only be covered as a Dependent of one Employee.

Each person must be insured by an individual or policy or contract that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans to be eligible for insurance under the Policy.

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

Initial Enrollment

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

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

Coverage Effective Date

Coverage will start on the latest to occur of:

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

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

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

Deferred Coverage Effective Date

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

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

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

This provision does not apply to:

- 1) any newborn Dependent Child, regardless of Confinement; or
- 2) any disabled child who qualifies under the definition of Dependent Child(ren).

Changes in Coverage

An Employee may:

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

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

- 1) the Policy Anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
 - 2) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
 - 3) the date on which the change is requested following a Change in Family Status;
- subject to the Deferred Coverage Effective Date provision.

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

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

New Dependent Coverage

If You:

- 1) marry or enter a partnership with an individual who satisfies the definition of Spouse; or
- 2) acquire a child who satisfies the definition of Dependent Child(ren);

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

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

TERMINATION OF COVERAGE

Termination of Coverage

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

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

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

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

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

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

REINSTATEMENT OF COVERAGE

Reinstatement of Coverage

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

- 1) returns to an Eligible Class within 12 month(s) from the date coverage ended; and
- 2) requests reinstatement within 31 days from their return to an Eligible Class, if coverage requires an election under the Policy;

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

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

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

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

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

CONTINUATION

CONTINUATION

Continuation

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

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

- 1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf); and
- 2) the Policyholder must approve the continuation.

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

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

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

Continuation Option(s)

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

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

EXTENDED CONTINUATION

Extended Continuation

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

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

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

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

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

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

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

Requesting Extended Continuation

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

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

Coverage continued under this provision:

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

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

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

CRITICAL ILLNESS BENEFITS

CANCER & BENIGN TUMOR CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Cancer & Benign Tumor Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Cancer & Benign Tumor Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced or metastasized condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Reoccurrence Benefit

We will pay the applicable Reoccurrence Benefit Amount shown in the Benefit Schedule for another Diagnosis of the same Critical Illness for a Covered Person in the Cancer & Benign Tumor Category for which a benefit was previously paid under the Policy if:

- 1) the Reoccurrence Benefit Separation Period has been satisfied; and
- 2) there is a declaration of Complete Remission/No Evidence of Disease for a Covered Person by the primary treating Physician for the prior Diagnosis of the same Critical Illness.

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

Additional Requirements

For **Cancer (Invasive), Carcinoma in Situ (Non-Invasive), Specified Skin Cancer** or **Bone Marrow Failure**, the following will be required for Proof of Loss:

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

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

For the **Early Diagnosis** of a **Benign Brain or Spinal Cord (Intradural) Tumor**, the following will be required for Proof of Loss:

- 1) a Pathological Diagnosis and results of any neuroradiology exams (CT scan, MRI or other reliable imaging techniques); or
- 2) a Clinical Diagnosis based on the following:
 - a) medical evidence or diagnostic testing that supports the Diagnosis; and
 - b) a Physician is treating the Covered Person for a Benign Brain or Spinal Cord (Intradural) Tumor;

that demonstrates that the definition of Benign Brain or Spinal Cord (Intradural) Tumor has been met for which:

- 1) neurological deficits have been observed and documented by a Physician; and
- 2) Surgery or radiation therapy is not currently recommended by a Physician for Treatment.

For the **Advanced Diagnosis** of a **Benign Brain or Spinal Cord (Intradural) Tumor**, the following will be required for Proof of Loss:

- 1) a Pathological Diagnosis and results of any neuroradiology exams (CT scan, MRI or other reliable imaging techniques); or
- 2) a Clinical Diagnosis based on the following:

- a) medical evidence or diagnostic testing that supports the Diagnosis; and
- b) a Physician is treating the Covered Person for a Benign Brain or Spinal Cord (Intradural) Tumor; that demonstrates that the definition of Benign Brain or Spinal Cord (Intradural) Tumor has been met:
 - 1) for which Surgery or radiation therapy is recommended by a Physician for Treatment; or
 - 2) resulting in one or more Permanent Neurological Deficits attributable to the Benign Brain or Spinal Cord (Intradural) Tumor.

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

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

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

HEART & VASCULAR CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Heart & Vascular Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Heart & Vascular Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Reoccurrence Benefit

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

Additional Requirements

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

- 1) a Pathological Diagnosis and results of any cardiac exams (EKG, echocardiogram, MRI or other reliable tests or imaging techniques); or
- 2) a Clinical Diagnosis based on the following:
 - a) medical evidence or diagnostic testing that supports the Diagnosis; and
 - b) a Physician is treating the Covered Person for a Heart Attack (Myocardial Infarction);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MAJOR ORGAN CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Major Organ Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Major Organ Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Reoccurrence Benefit

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

Additional Requirements

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

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

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

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

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

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

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

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

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

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

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

NEUROLOGICAL CONDITIONS CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Neurological Conditions Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Neurological Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Additional Requirements

For the **Advanced Diagnosis of Dementia**, a Clinical Diagnosis based on the following:

- 1) medical evidence, cognitive testing or diagnostic testing that supports the Diagnosis; and
- 2) a Physician is treating the Covered Person for Dementia;

that demonstrates that the definition of Dementia has been met, for which cognitive deficits are moderate or severe, consistent with:

- 1) a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 4 or higher; or
- 2) Clinical Dementia Rating Scale (CDR) score of 2 or higher;

will be required for Proof of Loss.

For the **Advanced Diagnosis of Parkinson's Disease**, a Clinical Diagnosis based on the following:

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

that demonstrates that the definition of Parkinson's Disease has been met, for which physical and nervous symptoms are mild to moderate consistent with:

- 1) a Hoehn and Yahr Scale Stage 4 or higher; or
- 2) Unified Parkinson's Disease Rating Scale Part 4;

will be required for Proof of Loss.

For the **Advanced Diagnosis of Amyotrophic Lateral Sclerosis (ALS)**, a Clinical Diagnosis based on the following:

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

that demonstrates that the definition of Amyotrophic Lateral Sclerosis (ALS) has been met, for which the Covered Person is classified as "Middle Stage" or higher according to the Muscular Dystrophy Association, will be required for Proof of Loss.

For the **Advanced Diagnosis of Multiple Sclerosis (MS)**, a Clinical Diagnosis based on the following:

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

that demonstrates that the definition of Multiple Sclerosis (MS) has been met, for which the Covered Person is classified with:

- 1) Secondary progressive MS (SPMS); or
- 2) Primary progressive MS (PPMS);

will be required for Proof of Loss.

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

INFECTIOUS CONDITIONS CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Infectious Conditions Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Infectious Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Additional Requirements

For the **Diagnosis of a Severe Infectious Disease (Requiring Hospitalization)**, a Clinical Diagnosis based on the following:

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

that results in a Covered Person being Confined to a Hospital for 5 or more consecutive days, will be required for Proof of Loss.

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

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

FUNCTIONAL LOSS & CATASTROPHIC CONDITIONS CATEGORY BENEFITS

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

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

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Functional Loss & Catastrophic Conditions Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Functional Loss & Catastrophic Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Reoccurrence Benefit for Coma

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

Additional Requirements

For the Diagnosis of:

- 1) **Coma;**
- 2) **Loss of Hearing;**
- 3) **Loss of Sight;**
- 4) **Loss of Speech;** or
- 5) **Permanent Paralysis;**

a Clinical Diagnosis based on the following:

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

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

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

CHILD CONDITIONS CATEGORY BENEFITS

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

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

Benefits are only payable for a Critical Illness that is Diagnosed for a Covered Person while covered under the Policy. We will not pay benefits for any Critical Illness included in the Child Conditions Category:

- 1) if a Covered Person was Diagnosed with such illness or condition, regardless of symptoms, severity or incapacity, prior to the Covered Person's effective date of coverage under the Policy; or
- 2) for the Diagnosis of any Critical Illness for a stillborn child.

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

Initial Occurrence Benefit

We will pay the applicable Initial Occurrence Benefit Amount shown in the Benefit Schedule if a Covered Person is Diagnosed with a Critical Illness included in the Child Conditions Category.

In the event a Covered Person is Diagnosed with a Critical Illness in the Child Conditions Category for which an Initial Occurrence Benefit was previously paid by Us, and that Critical Illness is subsequently Diagnosed as a more advanced condition for which a higher benefit is payable, We will pay any difference in the two amounts as an additional benefit amount. The Initial Occurrence Benefit Separation Period is not applicable in this circumstance.

Additional Requirements

For the **Early Diagnosis** of a **Cerebral Palsy**, a Clinical Diagnosis based on the following:

- 1) medical evidence or diagnostic testing that supports the Diagnosis; and
- 2) a Physician is treating the Covered Person for Cerebral Palsy;

that demonstrates that the definition of Cerebral Palsy has been met, for which the Covered Person is:

- 1) age 2 or younger; or
- 2) older than age 2 and is classified by a Physician as Level I or II on the Gross Motor Function Classification System – Expanded and Revised (GMFCS – E&R);

will be required for Proof of Loss.

For the **Advanced Diagnosis** of **Cerebral Palsy**, a Clinical Diagnosis based on the following:

- 1) medical evidence or diagnostic testing that supports the Diagnosis; and
- 2) a Physician is treating the Covered Person for Cerebral Palsy;

that demonstrates that the definition of Cerebral Palsy has been met, for which the Covered Person is:

- 1) older than age 2; and
- 2) is classified by a Physician as Level III or higher on the Gross Motor Function Classification System – Expanded and Revised (GMFCS – E&R);

will be required for Proof of Loss.

For the Diagnosis of:

- 1) **Congenital Heart Defect;**
- 2) **Congenital Metabolic Disorder;**
- 3) **Genetic Disorder;** or
- 4) **Structural Congenital Defect;**

a Clinical Diagnosis based on the following:

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

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

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

ADDITIONAL BENEFIT(S)

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

The Benefit Amounts shown in the Benefit Schedule may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the following provisions. Insurance must be in effect for a Covered

Person at the time the test, screening, evaluation or service is rendered or received by the Covered Person for any Additional Benefits to be payable.

Health Screening Benefit

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

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

GENERAL LIMITATIONS & EXCLUSIONS

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

Initial Occurrence Benefit Separation Period

Once a Critical Illness is Diagnosed for which a benefit is payable for a Covered Person, in order for an Initial Occurrence Benefit to be payable for any other Critical Illness, the Initial Occurrence Benefit Separation Period shown in the Benefit Schedule must be satisfied.

In the event the Diagnosis of any other Critical Illness occurs for a Covered Person within the Initial Occurrence Benefit Separation Period, either of the following will apply:

- 1) if the benefit amount We paid for the most recent prior Critical Illness is less than the Initial Occurrence Benefit Amount We would otherwise pay for the new Critical Illness, We will pay the difference in the two amounts as an additional benefit amount; or
- 2) if the benefit amount We paid for the most recent prior Critical Illness is equal to or greater than the Initial Occurrence Benefit Amount We would otherwise pay for the new Critical Illness, no additional benefit amount is payable.

The following illustrative examples are provided to help You understand how the Initial Occurrence Benefit Separation Period may be applied. The examples do not necessarily reflect the terms of Your specific coverage under the Policy. Both examples assume a Coverage Amount of \$20,000 and an Initial Occurrence Benefit Separation Period of 30 days.

EXAMPLE 1	
<i>Diagnosis Information</i>	<i>Outcome</i>
A Critical Illness with a benefit amount of 100% of the Coverage Amount is Diagnosed on January 17. This is the first Diagnosis for the Covered Person while insured under the Policy.	This Critical Illness is eligible for benefits, so a benefit of \$20,000 is payable.
The Covered Person is Diagnosed with a different Critical Illness with a benefit amount of 100% of the Coverage Amount on February 9 of the same year.	This Critical Illness is not eligible for benefits because this Diagnosis occurred within the Initial Occurrence Benefit Separation Period and a benefit amount of 100% of the Coverage Amount was paid for the first Critical Illness.
The Covered Person is Diagnosed with yet another Critical Illness with a benefit amount of 50% of the Coverage Amount on November 22 of the same year.	This Critical Illness is eligible for benefits because this Diagnosis occurred outside of the Initial Occurrence Benefit Separation Period, so a benefit of \$10,000 is payable.

EXAMPLE 2	
<i>Diagnosis Information</i>	<i>Outcome</i>
A Critical Illness with a benefit amount of 50% of the Coverage Amount is Diagnosed on January 17. This is the first Diagnosis for the Covered Person while insured under the Policy.	This Critical Illness is eligible for benefits, so a benefit of \$10,000 is payable.
The Covered Person is Diagnosed with a different Critical Illness with a benefit amount of 100% of	This Critical Illness is eligible for benefits. Even though this Diagnosis occurred within the Initial

the Coverage Amount on February 9 of the same year.	Occurrence Benefit Separation Period, since a benefit amount of only 50% of the Coverage Amount was paid for the first Critical Illness, the difference in the two amounts – \$10,000 – is payable.
The Covered Person is Diagnosed with yet another Critical Illness with a benefit amount of 100% of the Coverage Amount on November 22 of the same year.	This Critical Illness is eligible for benefits because this Diagnosis occurred outside of the Initial Occurrence Benefit Separation Period, so a benefit of \$20,000 is payable.

Reoccurrence Benefit Separation Period

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

The following illustrative example is provided to help You understand how the Reoccurrence Benefit Separation Period may be applied. The example does not necessarily reflect the terms of Your specific coverage under the Policy. The example assumes a Coverage Amount of \$20,000 and a Reoccurrence Benefit Separation Period of 180 days.

EXAMPLE	
<i>Diagnosis Information</i>	<i>Outcome</i>
A Critical Illness with a benefit amount of 100% of the Coverage Amount is Diagnosed on January 5. This is the first Diagnosis for the Covered Person while insured under the Policy.	This Critical Illness is eligible for benefits. A benefit of \$20,000 is payable.
The Covered Person is Diagnosed with the same Critical Illness with a Reoccurrence Benefit Amount of 100% on February 2 of the same year.	This Critical Illness is not eligible for benefits because this Diagnosis occurred within the Reoccurrence Benefit Separation Period.
The Covered Person is again Diagnosed with the same Critical Illness with a Reoccurrence Benefit Amount of 100% on March 17 of the following year.	This Critical Illness is eligible for benefits because the Diagnosis occurred outside of the Reoccurrence Benefit Separation Period. A benefit of \$20,000 is payable.

Policy Benefit Maximum

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

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

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

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

The following example is provided to help You understand how the Policy Benefit Maximum may be applied. The example does not necessarily reflect the terms of Your specific coverage under the Policy. The example assumes a Coverage Amount of \$20,000 and a Policy Benefit Maximum of 500%.

EXAMPLE	
<i>Diagnosis Information</i>	<i>Outcome</i>
A Critical Illness with a benefit amount of 100% of the Coverage Amount is Diagnosed on January 17. This is the first Diagnosis for the Covered Person while insured under the Policy.	This Critical Illness is eligible for benefits. A benefit of \$20,000 is payable. The remaining Policy Benefit Maximum for the Covered Person is reduced from 500% to 400%.
The Covered Person is Diagnosed with a different Critical Illness with a benefit amount of 100% of the Coverage Amount on February 2 of the	This Critical Illness is eligible for benefits because this Diagnosis occurred outside of any applicable separation or limitation periods. A benefit of

following year.	\$20,000 is payable. The remaining Policy Benefit Maximum for the Covered Person is reduced from 400% to 300%.
Two years later, the Covered Person is Diagnosed with yet another Critical Illness with a benefit amount of 100% of the Coverage Amount.	This Critical Illness is eligible for benefits because this Diagnosis occurred outside of any applicable separation or limitation periods. A benefit of \$20,000 is payable. The remaining Policy Benefit Maximum for the Covered Person is reduced from 300% to 200%. Benefits for future Diagnoses of a Critical Illness will remain available under the Policy for the Covered Person until the Policy Benefit Maximum is reduced to 0%.

Exclusions

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

- 1) intentional self-inflicted illness or Injury;
- 2) voluntarily taking or using any drug, narcotic, medication or sedative, unless it is taken or used as prescribed by a Physician;
- 3) voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities (except for misdemeanor violations), or voluntary engagement in an illegal occupation;
- 4) incarceration or imprisonment in any type of penal or detention facility;
- 5) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate; or
- 6) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military, or working in an area of war whether voluntarily or as required by an employer.

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

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

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

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

CLAIM PROVISIONS

Notice of Claim

Written notice of claim may be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of a Covered Person or the beneficiary to Us, or to any authorized agent of Ours, with information sufficient to identify the Covered Person, shall be deemed notice to Us.

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

Notice of claim may be submitted:

- 1) via mail to The Hartford's Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099;
- 2) via fax to (469) 417-1952; or
- 3) per the instructions included on the applicable claim form.

Claim Forms

We, upon receipt of Notice of Claim, will furnish to the claimant such forms as are usually furnished for filing Proof of Loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, Written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us in case of claim for loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claims

Benefits payable under the Policy will be paid immediately upon Our receipt of due Written Proof of Loss.

Payment of Claims

All benefits are payable to You, if living. Any benefits unpaid at the time of Your death will be paid to Your designated beneficiary(ies), or if none, then in the following order to:

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

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine a Covered Person when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Beneficiary Designation

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

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

Change of Beneficiary

Unless You make an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to You and the consent of any beneficiary or beneficiaries shall not be requisite to surrender or assignment of the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

Claim Denial

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

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

Claim Appeal

On any claim, the claimant or their representative may appeal to Us for a full and fair review. To do so, the claimant:

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

We will respond in Writing with Our decision on the claim. If You are not satisfied with the decision, You have the right to contact the California Insurance Department to review Your dispute.

Errors Related to Benefit Payments

We have the responsibility to make additional benefit payments if any underpayments have been made under the Policy.

We also have the right to recover from You or the recipient of benefits any amount that is an overpayment. You or the recipient of benefits has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days. If reimbursement is not made in a timely manner, We shall:

- 1) recover such overpayments from:
 - a) You;
 - b) any other person to or for whom payment was made; or
 - c) Your estate; and
- 2) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made.

GENERAL PROVISIONS

Entire Contract and Changes

This insurance is provided under a contract of group insurance with the Policyholder. The Policy, including endorsements and attached papers, if any, constitutes the entire contract of insurance. No changes in the Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Time Limit on Certain Defenses

After two years from the date of issue of the Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for the Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of the two-year period.

No claim for loss incurred after two years from the effective date of the insurance coverage shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of coverage under the Policy.

Grace Period

A grace period of 60 days will be granted for the payment of each premium falling due after the first premium, during the grace period the Policy shall continue in force.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after Written Proof of Loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time Written Proof of Loss is required to be furnished.

Misstatement of Age

If the age of any Covered Person has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

Unpaid Premium

Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Conformity with State Statutes

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Primary Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Periods

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

Assignment

You have the right to absolutely assign Your rights and interest under the Policy including, but not limited to, the following:

- 1) the right to make any contributions required to keep the insurance in force; and
- 2) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under the Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under the Policy.

**NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION**

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, an individual is covered by the Association if the insurer was a member of the Association **and** the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

Amounts of Coverage

The basic coverage protections provided by the Association are as follows.

▪ **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
80% of death benefits but not to exceed \$300,000
80% of cash surrender or withdrawal values but not to exceed \$100,000
- Annuities and Structured Settlement Annuities
80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000

The maximum amount of protection provided by the Association to an individual, for **all** life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

▪ **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

(please turn to next page)

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

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



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

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

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

Uses and Disclosures of Your PHI

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

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

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

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

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

Examples of activities related to healthcare operations include: quality improvement; fraud and abuse prevention and detection;

case management and medical review; underwriting; and complaint resolution.

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

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

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

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

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

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

Your Privacy Rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hartford's Duties

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

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