YOUR BENEFIT PLAN

THE HERTZ CORPORATION

Critical Illness

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Maryland

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

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. you may access the website at 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 claim administrator as follows:

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

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

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

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

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

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.

Alaska:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. The **Spouse** definition will always include a registered domestic partnership, any individual who is a partner to a civil union, and any other relationship allowed by state law.

Arizona:

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

Arkansas:

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

California:

1. **NOTICE:** You and Your Dependent(s) must be insured with major medical insurance in order to be eligible under

the Policy.

2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, does not apply to You. The following requirement applies to You:

   Eligibility Determination:
   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine the Covered Person's eligibility for benefits for any claim the Covered Person or the Covered Person's estate make on the Policy. We will:
   1) obtain with the Covered Person's cooperation and authorization if required by law, only such information that is necessary to evaluate his/her claim and decide whether to accept or deny his/her claim for benefits. We may obtain this information from the Covered Person's Claim Notice, submitted proofs of loss, statements, or other materials provided by the Covered Person or others on the Covered Person's behalf; or, at Our expense. We may obtain necessary information, or have the Covered Person physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at the Covered Person's option and at his/her expense, the Covered Person may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of the Covered Person's choice. The Covered Person should provide Us with all information that he/she want Us to consider regarding his/her claim;
   2) as a part of Our routine operations, We will apply the terms of the Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
   3) if We approve the Covered Person's claim, We will review Our decision to approve his/her claim for benefits as often as is reasonably necessary to determine his/her continued eligibility for benefits;
   4) if We deny the Covered Person's claim, We will explain in writing to the Covered Person the basis for an adverse determination in accordance with the Policy as described in the provision entitled **Claim Denial**.

   In the event We deny the Covered Person's claim for benefits, in whole or in part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled **Claim Appeal**. If the Covered Person does not appeal the decision to Us, then the decision will be Our final decision.

3. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833
   Web Address: www.insurance.ca.gov

Colorado:

1. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition, located in the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
2. The **Spouse** definition also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.
3. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, the Covered Person is entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.
4. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Connecticut:

1. **NOTICE:** The **Policy** provides limited/supplemental coverage only and does not replace major medical insurance.
2. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
3. Benefits will be payable within 30 days from the date We receive Proof of Loss, as defined in the **Claims Provisions** section of the Certificate; unless if shown as less.
4. **Dependent Child(ren) Coverage Amount**, shown in the **Benefit Schedule**, will be at least 25% of the Primary Insured's Coverage Amount; if elected.

Florida:

1. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Georgia:

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

Idaho:

1. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The continuously insured time period, as shown in the **Pre-existing Condition Limitation** of the **Limitations and Exclusions** section**,** is 6 consecutive months; unless if shown as less.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the Limitations and Exclusions section, is 6 consecutive months; unless if shown as less.
4. We will pay benefits immediately upon receipt of Proof of Loss.
5. The **Coverage Amount(s),** as shown in the **Benefit Schedule**, must be elected in increments $1,000.
6. **Dependent Child(ren)** coverage, as shown in the **Definitions** section, will continue past the attainment age if the child has a disability or handicap which prevents him/her from securing sustainable employment and the child is dependent upon You for financial support. Proof of such handicap or disability must be provided upon request; however after 2 years such proof will only be required once per year.
7. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

   This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:
   Illinois Department of Insurance
   320 W. Washington Street
   Springfield, Illinois 62767-0001

   Illinois Department of Insurance
   115 S. LaSalle Street
   13th Floor
   Chicago, Illinois 60603

   Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
   Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. In accordance with Illinois law, insurers are required to provide the following NOTICE to applicants of insurance policies issued in Illinois.

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

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next

of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

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

Indiana:

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

Kansas:

1. The following requirement applies to You:

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

Louisiana:

1. The **Reinstatement after Military Service** provision, if not shown in the **Continuation Provisions section,** applies to you:

   Reinstatement after Military Service: If:
   1) Your coverage terminates because You enter active military service; and
   2) You are rehired within 12 months of the date You return from active military service;

   then coverage for You may be reinstated, provided You request such reinstatement within 30 days of the date You return to work.

   The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage terminated; and
   2) not be subject to any Waiting Period for Coverage; and
   3) be subject to all the terms and provisions of the Policy.

Maine:

1. **NOTICE:** The Policy provides for limited benefits and does not cover all medical expenses. The Certificate, Outline of Coverage, and Buyer's Guide to Cancer Insurance should be reviewed.
2. The continuously insured time period, as shown in the **Pre-existing Condition Limitation** of the **Limitations and Exclusions** section, is 12 consecutive months; unless if shown as less.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
4. Coverage for **Dependent Child(ren)** as shown in the Definitions section, terminates at age 19 for non-students; unless if shown as higher.
5. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
6. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Michigan:

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

Montana:

1. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months, unless if shown as less.
2. Benefits and coverage amounts for a newborn or newly adopted child will be equal to the benefits and coverage amounts offered under the Policy for Dependent Child(ren), as shown in the **Benefit Schedule**.
3. Coverage for a newly adopted child, as described in the **Eligibility and Enrollment** section, will cease immediately if placement is disrupted or the child no longer is in the custody of You or Your Spouse.
4. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment of any illness or injury within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months, or less if shown in the Certificate. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until the Covered Person has been continuously insured for 6 consecutive months, or less if shown in the Certificate.
3. **Proof of Loss,** as shown in the **Claim Provisions** section, must be provided within 90 days of the date of loss.
4. Part-time employees who work at least 15 hours per week are eligible for coverage.
5. A Dependent will no longer meet the definition of **Dependent Child** upon attainment of age 26.
6. Spouse coverage may be continued under the Policy even after divorce or separation. Coverage may be continued to a maximum of 3 years or earlier if ordered by a divorce decree. The continuation will cease if the Primary Insured dies or the former Spouse remarries.
7. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
8. **Notice: READ YOUR CERTIFICATE CAREFULLY** - You have a 30 day right from the Primary Insured's Coverage Effective Date to examine Your Certificate. If You are not satisfied, You may return it to Us within 30 days from the date You received Your Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
9. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
10. The following **Extension of Coverage while Disabled** provision is added to the **Continuation Provisions** section of the Certificate:

    Extension of Coverage while Disabled
    If You are Disabled when coverage would otherwise terminate because:
    1) You are no longer eligible for insurance or are no longer in an Eligible Class; or
    2) the Policy terminated;

    coverage will be extended for 90 days after it would otherwise terminate, while Disability continues.

    The following definitions apply to this provision:
    Disabled, Disability means that a significant change in Your mental or physical functional capacity has occurred, as a result of which during the initial 12 months of continuous disability You are:
    1) unable to perform the Material Duties of Your Regular Occupation; and/or
    2) receiving disability benefits through a disability insurance plan (or equivalent) sponsored by the Policyholder.

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

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

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

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

11. We will refund the pro rata portion of any premium paid for You or Your covered Dependents while You or Your covered Dependents are in the armed forces on full-time active duty, if coverage is excluded during this period.
12. **Notice:** This is a Limited Policy - Read it Carefully
13. **Notice:** This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the Outline of Coverage and the "Buyer's Guide."

New Jersey:

1. All coverage amounts, as shown in the **Benefits Schedule**, must be elected in increments of $1,000. Spouse and Dependent Child(ren) coverage will be a minimum of 25% of the **Primary Insured Coverage Amount**.
2. The **Lodging Benefit, Transportation Benefit, Prosthesis/Wig Benefit, Rehabilitation Benefit, Home Health Care Benefit,** and **Physical Therapy Benefits**, if shown in the **Benefit Schedule** section, are not available to New Jersey residents.
3. The **Health Screening Benefit**, if shown in the **Benefit Schedule** section, is payable at $50 per year.

New Mexico:

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

b. licensed to practice in the jurisdiction where care is being given;
c. operating within the scope of his or her license; and
d. not the Covered Person or a Family Member.

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

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

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

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

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

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

F. After a **Covered Person** has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period. In order to be used, the statement must be in writing and signed by You and Your Spouse.

New York:

1. **NOTICE:** The Certificate is a group certificate. The Certificate provides specified disease coverage ONLY. The Certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Department of Financial Services.

North Carolina:

1. No statements will be used to reduce or deny a claim if the Covered Person has been insured under the Policy for at least 2 years. Prior to 2 years, such statement must be in writing and signed by the Covered Person in order to be used.
2. **Notice of Claim,** as shown in the **Claim Provisions** section**,** should be sent to:
   WebTPA, Inc.,
   P.O. Box 99906
   Grapevine, TX 76099.
3. **Proof of Loss,** as shown in the **Claim Provisions** section, must be provided within 180 days from the date of loss.
4. Benefits will be paid immediately upon receipt of **Proof of Loss**.

Oregon:

1. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.
2. The **Spouse** definition will always include domestic partners, civil unions, and any other arrangement allowable by state law.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section, is not applicable.
2. Coverage will be continued for a period of at least 5 but no greater than 30 consecutive days if Your Dependent enters into active military service outside of the continental United States. Please see Your Employer for additional eligibility requirements.

South Dakota:

1. No benefit or increase in benefits will be payable for a Critical Illness that was caused or contributed by a **Pre-existing Condition** as described in the **Exclusions and Limitations** section during the first 12 months from the Policy Effective Date.
2. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
3. The definition of **Physician** will include a Family Member if such person is the only doctor in the area acting within the scope of practice.

Texas:

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

Have a complaint or need help?

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

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

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

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

Teléfono gratuito: 1-800-523-2233

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

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

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

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

Utah:

1. Proof of disability or handicap of a **Dependent Child**, as described in the **Definitions** section, will not be requested more frequently than once every two years.

Vermont:

1. The **Waiting Period**, if shown in the **Benefit Schedule**, is not applicable.

Virginia:

1. The definition of **Spouse** only includes anyone who is recognized as a spouse under Virginia state law.
2. Domestic partners and other relationships allowable by Virginia state law are eligible for Dependent coverage; if Dependent coverage is available under the Policy.
3. **For Your Questions and Complaints:**
   State Corporation Commission
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   1(804) 371-9691 (inside Virginia)
   1(877) 310-6560 (outside Virginia)

Wisconsin:

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

GROUP CRITICAL ILLNESS 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: THE HERTZ CORPORATION
Policy Number: VCI-803546
Policy Effective Date: July 1, 2021
Policy Anniversary Date: January 1

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

Signed for the Company

Kevin Barnett, *Secretary*

Michael J. Fish, *Head of Group Benefits*

THIS IS A LIMITED BENEFIT CERTIFICATE: This Certificate provides limited or supplemental coverage. It pays benefits ONLY upon the occurrence and Diagnosis of a Critical Illness with the exception of the Health Screening Benefit. This Certificate does not provide benefits for any other disease, sickness or incapacity. Benefits provided are supplemental and are not intended to substitute for medical coverage or disability insurance.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from Us.

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

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

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BENEFIT SCHEDULE

The benefits described herein are those in effect as of: February 1, 2026.

Eligible Class(es) for Coverage: All Full-time and Part-time Active Employees scheduled to work at least 20 hours per week and who are citizens or legal residents of the United States of America, its territories and protectorates; excluding temporary, leased or seasonal employees.

Waiting Period:

1) 60 days - if You are Actively at Work for the Policyholder on the Policy Effective Date; or
2) 30 days - if You start working for the Policyholder after the Policy Effective Date.

The time period(s) referenced above is continuous.

Cost of Coverage:
Contributory – You must contribute toward the cost of coverage.

Coverage Amount:

Primary Insured: Option 1: $15,000

Option 2: $30,000

Spouse: 50% of the Primary Insured Coverage Amount

Dependent Child(ren): 50% of the Primary Insured Coverage Amount

Primary Insured Coverage Maximum:
You may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 500% of the Primary Insured's Critical Illness Coverage Amount is reached in Your lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Spouse Coverage Maximum:
Your Spouse may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 500% of the Spouse's Critical Illness Coverage Amount is reached in Your Spouse's lifetime under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

Child(ren) Coverage Maximum:
Each Child may receive multiple Critical Illness Benefit payments and Recurrence Benefit payments until a maximum of 300% of the Child's Coverage Amount is reached while covered as a Dependent Child under the Policy. The Coverage Maximum does not include any Additional Critical Illness Benefits.

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

CRITICAL ILLNESS BENEFITS

Critical Illnesses	Percentage of Coverage Amount
Cancer Benefits	
Invasive Cancer	100%
Non-Invasive Cancer	25%
Benign Brain Tumor	100%
Vascular Benefits	
Heart Transplant	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Bypass Graft	25%
Other Specified Critical Illness Benefits	
Coma	100%
Paralysis	100%
Major Organ Transplant	100%
End Stage Renal Disease	100%
Loss of Hearing	100%
Loss of Speech	100%
Loss of Vision	100%
Neurological Benefits	
Advanced Parkinson's Disease	100%
Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease")	100%

Child-Specified Benefits	Percentage of Coverage Amount
Muscular Dystrophy	100%
Cerebral Palsy	100%
Cystic Fibrosis	100%
Spina Bifida	100%
Congenital Heart Disease	100%

Each covered Critical Illness Benefit listed will only be paid once for each Covered Person.

Recurrence Benefit	Percentage of Original Benefit Amount
Invasive Cancer	100%
Benign Brain Tumor	100%
Heart Transplant	100%
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coma	100%
Major Organ Transplant	100%

Subject to the Covered Person’s coverage maximum shown above, the Recurrence Benefit is only payable if a Critical Illness Benefit has been paid for the same Critical Illness. In order to receive a Recurrence Benefit, all other conditions stated in the Recurrence Benefit provision must be satisfied. Only one Recurrence Benefit is payable for each covered benefit.

ADDITIONAL CRITICAL ILLNESS BENEFITS

Benefits	Coverage Amount
Health Screening Benefit	$50 per day

DEFINITIONS

Active Employee means an employee who works for the Policyholder on a regular basis in the usual course of the Policyholder's business. This must be at least the numbers of hours shown in the Benefit Schedule.

Actively at Work means that You are performing all the regular duties of Your job in the usual way and for the usual number of hours at the Policyholder's normal place of business or a site where the Policyholder's business requires You to travel.

You are considered Actively at Work on any day that is not Your regular scheduled work day (e.g., You are on vacation or holiday) as long as You were Actively at Work on Your immediately preceding scheduled work day.

Advanced Parkinson's Disease means a condition Diagnosed as Parkinson's Disease which has progressed to a classification of Stage 4 or greater. Diagnosis must be made by a board certified or board eligible neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. Other Parkinsonian syndromes are not included in this definition.

The initial Diagnosis of Advanced Parkinson's Disease must occur while the Covered Person is covered under the Policy.

Amyotrophic Lateral Sclerosis (ALS or "Lou Gehrig's Disease") means a condition Diagnosed as progressive degenerative motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a degeneration of anterior horn cells of the spinal cord and cranial nerves and is Middle Stage according to the Muscular Dystrophy Association. Other motor neuron diseases are not considered to be ALS. ALS must be Diagnosed by a Physician who is a board certified neurologist based on generally acceptable principles of medicine.

The initial Diagnosis of ALS must occur while the Covered Person is covered under the Policy.

Aneurysm means a condition Diagnosed as a localized, blood-filled dilation of a blood vessel caused by disease or weakening of the vessel wall in the brain, carotid arteries, or aorta for which surgical correction has been performed or is Medically Necessary. Aorta refers to the thoracic and abdominal aorta, but not its branches. Diagnosis must be supported by medical records which include radiographically specific studies such as, but not limited to, angiography, CT scan, MRI, or ultrasound.

Angioplasty/Stent means a condition Diagnosed as heart disease that has progressed such that reconstitution or recanalization of a blood vessel is Medically Necessary. Angioplasty surgery may involve balloon dilation, mechanical stripping of intima, forceful injection of fibrinolytics or placement of a stent.

Annual Enrollment Period means a date determined by the Policyholder on a yearly basis.

Benign Brain Tumor means a condition Diagnosed as a non-malignant tumor or cyst in the brain, cranial nerves or meninges within the skull with a minimum size of 1 cm, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms. The tumor, including its size, should be documented on an MRI of the brain (with and without contrast) or by pathological diagnosis. If the Covered Person is unable to undergo an MRI of the brain (the study is deemed inappropriate for safety reasons such as the presence of metallic foreign bodies; mechanical reasons such as body habitus; or unavailability), then the tumor should be documented by a CT scan of the head, with and without contrast.

Benign Brain Tumor does not include:

1) tumors in the pituitary gland; or
2) angiomas.

Cerebral Palsy means a condition Diagnosed as a non-progressive neurological defect affecting muscle control characterized by spasticity and incoordination of movements. Other similar conditions such as degenerative nervous disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown, are not included in this definition.

The Diagnosis of Cerebral Palsy must be made by a Physician board certified in neurology or a pediatrician who specializes in neurodevelopmental disorders.

The initial Diagnosis of Cerebral Palsy must occur while the Covered Person is covered under the Policy.

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

Change in Family Status means one of the following events:

1) an Employee gets married or enter into a legal relationship recognized as a Spouse;
2) an Employee and their Spouse divorce or legally terminate their relationship;
3) an Employee's child is born or an Employee adopts, an Employee receives a step child or becomes the legal guardian of a child;
4) an Employee's Spouse dies;
5) an Employee's child is no longer a Dependent Child or dies;
6) Your Spouse is no longer employed, which results in a loss of critical illness insurance sponsored by the Spouse's employer; or
7) an Employee has a change in classification from part-time to full-time or from full-time to part-time.

Coma means a condition Diagnosed as a continuous state of profound unconsciousness with no reaction to external stimuli which is not the result of a Stroke. The Coma must:

1) be due to disease;
2) be Diagnosed after the Policy Effective Date;
3) last for a period of 7 or more consecutive days; and
4) be rated/classified by at least one of the following scales:
    a) Rancho Los Amigos Scale (RLAS) as a level I or II;
    b) Glasgow Coma Scale values of 3 through 5; or
    c) the disability rate scale with values of 22 through 29.

The condition must require mechanical ventilation for respiratory assistance. For purposes of the Policy, Coma does not include a medically induced coma or a coma caused or contributed to by alcohol or substance abuse.

Congenital Heart Disease means a condition Diagnosed as at least one of the following covered heart conditions:

1) coarctation of the aorta;
2) Ebstein's anomaly;
3) Eisenmenger syndrome;
4) Tetralogy of Fallot;
5) transposition of the great vessels;
6) total anomalous pulmonary venous connection;
7) atresia of any heart valve;
8) single ventricle;
9) hypoplastic left heart syndrome;
10) truncus arteriosus;
11) double outlet left or right ventricle; or
12) any other congenital cardiac condition that requires life-saving surgery to survive.

It also means a specific condition for which it is Medically Necessary that open heart surgery be performed.

The Diagnosis of Congenital Heart Disease must be made by a Physician board certified in cardiology and must be supported by cardiac imaging. If the Covered Person is determined to be too ill to undergo surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

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

Coronary Artery Bypass Graft means a condition Diagnosed as heart disease that necessitates heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be Medically Necessary as determined by a Physician board certified in cardiology.

Coverage Amount is the dollar amount You or Your Dependents are covered for a Critical Illness.

Covered Person means the Primary Insured and all Dependents.

Critical Illness means any of the conditions shown in the Benefit Schedule.

Cystic Fibrosis means a condition Diagnosed as a recessive genetic disease affecting the lungs and pancreas, liver, and intestine. It is characterized by abnormal transport of chloride and sodium across the epithelium leading to thick viscous secretions. The Diagnosis of Cystic Fibrosis must be confirmed by a positive sweat test.

The initial Diagnosis of Cystic Fibrosis must occur while the Covered Person is covered under the Policy.

Dependent or Dependents means Your Spouse and Your Dependent Child(ren) covered by the Policy.

Dependent Child(ren) means Your or Your Spouse's natural children, step-children, foster children, legally adopted children, children placed into Your custody for adoption or children for whom You are ordered by a court or administrative order to provide coverage regardless of whether You are the custodial or non-custodial parent who 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 You for financial support;

and You have provided proof of his/her disability upon Our request, that child will continue to be a Dependent Child until these conditions cease to exist.

Diagnosed, Diagnosis means the definitive establishment of a Critical Illness through the use of clinical or laboratory findings. The Diagnosis must be made by a Physician who is a board certified specialist where required in the Policy.

End Stage Renal Disease means a condition Diagnosed as kidney disease which has resulted in permanent and irreversible failure of both kidneys requiring regular treatment by either hemodialysis or peritoneal dialysis on a no less than weekly basis, or for which kidney transplant is Medically Necessary.

Family Member means the Covered Person's parent, spouse, domestic partner, children, siblings, grandparent, aunt, uncle, first cousin, nephew or niece. This includes adopted, in-law and step-relatives.

Heart Attack means a condition Diagnosed as acute myocardial infarction resulting in the death of a portion of the heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart.

The Diagnosis must be made by a Physician board certified in cardiology. Significant electrocardiogram (EKG) changes must be seen and the Diagnosis of an acute myocardial infarction (heart attack) with resulting loss of normal heart function must be confirmed by one or both of the following:

1) a clinical picture of myocardial infarction with cardiac enzyme changes found in blood (elevated CK-MB isoenzyme fraction or elevated troponins);
2) confirmatory imaging tests such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

Heart Attack does not include:

1) established (old) myocardial infarction;
2) congestive heart failure;
3) atherosclerosis;
4) angina;
5) coronary artery disease;
6) or any other dysfunction of the cardiovascular system;
7) cardiac arrest not caused by a myocardial infarction; or
8) heart attacks that occur during clinical procedures.

In the event of death, an autopsy confirmation and/or death certificate identifying Heart Attack as the cause of death will be accepted.

Heart Transplant means:

1) a condition Diagnosed as heart failure due to heart disease and placed on a national transplant list such as UNOS; and
2) the irreversible failure of the Covered Person's heart has occurred for which a Physician has determined that the replacement of such organ with a human donor heart is Medically Necessary.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement on such list will be waived.

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

Invasive Cancer means a condition Diagnosed as the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells with invasion of normal tissue as diagnosed by a Physician, who is board certified in the medical specialty that is appropriate for the type of cancer involved.

Invasive Cancer includes any cancer classified as Stage 2 through 4, or its equivalent.

Invasive Cancer does not include a Diagnosis of Invasive Cancer for:

1) any tumor in the presence of human immuno-deficiency virus;
2) any non-melanoma skin cancer; or
3) any condition that is considered Non-Invasive Cancer.

Loss of Hearing means a condition Diagnosed as the irreversible loss of hearing for all sounds in both ears, due to disease. The Diagnosis of irreversible loss of hearing must be made by a licensed professional or specialist in the applicable field of medicine and established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels in both ears while utilizing a hearing aid.

The loss of hearing must occur after the Covered Person becomes insured under the Policy.

Loss of Speech means a condition Diagnosed as the irreversible loss of ability to speak, due to disease. The Diagnosis of irreversible loss of speech must be made by a licensed professional or specialist in the applicable field of medicine and must include documented evidence of the loss for at least 12 months.

The loss of speech must occur after the Covered Person becomes insured under the Policy.

Loss of Vision means a condition Diagnosed as the irreversible loss of vision in both eyes due to disease. The Diagnosis of irreversible loss of vision must be made by a licensed professional or specialist in the applicable field of medicine and must indicate that corrective visual acuity is equal to or worse than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes.

The irreversible loss of vision must occur after the Covered Person becomes insured under the Policy.

Major Organ Transplant means:

1) a Diagnosis of organ failure due to disease of the affected organ and have been placed on a national transplant list such as UNOS; and
2) the irreversible failure of the Covered Person's lung, pancreas or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is Medically Necessary; or
3) the irreversible failure of the Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is Medically Necessary. For this type of transplant, the requirement of placement on a national transplant list, such as UNOS, is specifically null in cases of live donor transplant.

Organs transplanted simultaneously with the heart are covered under Heart Transplant.

If the Covered Person is too ill for a transplant, but otherwise meets the criteria to be placed on the UNOS or other national transplant list, the placement requirement will be waived.

Medically Necessary means:

1) recommended by a Physician acting within the scope of his or her license; and
2) consistent with currently accepted medical practice.

Muscular Dystrophy means a condition Diagnosed as one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue. The Diagnosis of Muscular Dystrophy must be confirmed by electromyography and muscle biopsy. Spinal muscular atrophy does not satisfy the definition of Muscular Dystrophy.

Non-Invasive Cancer means a condition Diagnosed as:

1) Stage 1 or its equivalent; or
2) carcinoma in situ classified as TisN0M0, for which radiotherapy, intravenous chemotherapy, or surgical procedures are Medically Necessary to control or cure the disease.

Non-Invasive Cancer does not include a condition Diagnosed as:

1) any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
2) any tumor in the presence of human immuno-deficiency virus;
3) any non-melanoma skin cancer;
4) any melanoma in situ classified as TisN0M0 under TNM staging.

Paralysis means a condition Diagnosed as the complete and permanent loss of function of two or more limbs due to disease. Paralysis as a result of Stroke is excluded. The Diagnosis of Paralysis must include documented evidence of the illness that caused the Paralysis. As used herein, "limb" means an arm or leg.

The Paralysis must occur after the Covered Person becomes insured under the Policy.

Physician means a person who is:

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

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

Primary Insured refers to the Active Employee.

Prior Policy means the group Critical Illness insurance policy carried or sponsored by the Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Qualifying Event for You means any termination of coverage under the Policy, prior to age 80, in accordance with the Termination provision for any reason, except:

1) non-payment of premium; or
2) termination of the group Policy.

Qualifying Event for Your Spouse is Your death or divorce while You are insured under the Policy. The Qualifying Event must occur prior to Your Spouse's attainment of age 80.

Dependent Child(ren) coverage is continued if You or Your Spouse elect to continue coverage due to Your or Your Spouse's own Qualifying Event.

Spina Bifida means a congenital defect, Diagnosed by a Physician, caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following: hydrocephalus, paralysis, bowel problems and bladder problems relating to control of urine.

For purposes of the Policy, Spina Bifida does not include spina bifida occulta.

Spouse means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.

Stroke means a condition Diagnosed as a cerebrovascular accident including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis.

The diagnosis must be supported by:

1) evidence of persistent neurological deficits confirmed by a neurologist at least 30 days after the event; and
2) confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

Stroke does not mean a head injury, transient ischemic attack (TIA), or chronic cerebrovascular insufficiency.

Stroke does not include a Diagnosis of Stroke for:
1) cerebral symptoms due to migraine;
2) cerebral injury resulting from trauma or hypoxia; or
3) vascular disease affecting the eye or optic nerve or vestibular functions.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

Waiting Period means the length of time You must be a member in an Eligible Class before You can apply for insurance. The Waiting Period is shown in the Benefit Schedule.

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

You or **Your** refers to the Primary Insured.

ELIGIBILITY AND EFFECTIVE DATES

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

The Waiting Period will be reduced by the period of time You were an Active Employee with the Employer under the Prior Policy.

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

You may not cover Your Dependent if such Dependent is covered as an Active Employee under the Policy. No person can be insured as a Dependent of more than one employee under the Policy.

Enrollment:
To enroll You must:
1) complete and sign a group insurance enrollment form, which is satisfactory to Us, for Your and Your Dependent's coverage within 31 days of the date You are eligible for coverage; and
2) deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

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

Primary Insured's Coverage Effective Date:
Coverage will start on the latest to occur of:
1) the first of the month following the date You become eligible, if You enroll on or before that date;
2) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
3) the first day of the month following the last day of the additional enrollment event, if You enroll during an additional enrollment event; or
4) the first of the month following the date You enroll, if You do so within 31 days from the date You are eligible.

Continuity from a Prior Policy:
Critical Illness coverage under this Certificate will begin, and will not be deferred if, on the day before the Policy Effective Date, You were:

1) insured under the Prior Policy; and
2) Actively at Work or on an authorized family and medical leave;

but on the Policy Effective Date, You were not Actively at Work, but would otherwise meet the eligibility requirements of the Policy. However, Your Coverage Amount will be the lesser of the amount of Critical Illness Coverage Amount:

1) You had under the Prior Policy; or
2) shown in the Benefit Schedule.

Such amount of insurance under this provision is subject to any reductions in the Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination of Primary Insured's Coverage provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under the Policy.

Dependent Effective Date:
Coverage will start on the latest to occur of:

1) the first of the month following the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the Policy anniversary that coincides with or next follows the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
3) the first day of the month following the last day of the additional enrollment event, if You enroll during an additional enrollment event; or
4) the first of the month following the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

Dependent Continuity from a Prior Policy:
If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Dependent Coverage Amount of Insurance will be the lesser of the amount of Critical Illness insurance:

1) Your Dependents had under the Prior Policy; or
2) shown in the Schedule of Insurance.

Changes in Coverage:
You may change Your benefit option only:

1) during an Annual Enrollment Period or the first day of the month following the last day of the additional enrollment event; or
2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to the next higher option, if available.

If You enroll for a change in benefit option during an Annual Enrollment Period or any additional enrollment event, the change will take effect on the Policy Anniversary Date following the Annual Enrollment Period or the first day of the month following the last day of the additional enrollment event.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the date You enroll for the change.

Any such increase in coverage is subject to the Pre-existing Conditions Limitations.

Newborn and Newly Adopted Child Coverage:
If, while covered under the Policy, You:

1) have a newborn child;

2) adopt a child;
3) receive a foster child;
4) receive a stepchild; or
5) become the legal guardian or custodian of a child;

the child will become covered under the Policy for 60 days from the date of the event listed above; unless as otherwise specified below. Benefits and amounts will be the minimum amount for those We are providing for Dependent Children under the Policy at that time.

An adopted child's coverage will be effective from the moment of birth if the written adoption agreement has been entered into prior to the birth of the child.

Coverage of the new child will cease after 60 days unless You:
1) enroll the new child prior to the expiration of the 60 days; and
2) pay the additional required premium.

TERMINATION OF INSURANCE

Termination of Primary Insured's Coverage:
Your coverage will end on the earliest of the following:
1) the date the Policy terminates;
2) the last day of the month following the date You are no longer in a class eligible for coverage, or the Policy no longer covers Your class;
3) the date the required premium is due but not paid;
4) the last day of the month following the date You request We terminate Your coverage;
5) the last day of the month following the date the Policyholder terminates Your employment; or
6) the last day of the month following the date You are no longer Actively at Work;

unless continued in accordance with one of the Continuation Provisions or Extended Continuation as shown below.

Termination of Dependent Coverage:
Coverage for Your Dependent(s) will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the last day of the month following the date You are no longer eligible for Dependent coverage;
4) the last day of the month following the date We or the Policyholder terminate Dependent coverage;
5) the last day of the month following the date You request We terminate Dependent coverage;
6) the last day of the month following the date the child no longer meets the definition of Dependent Child; or
7) the last day of the month following the date that You and Your Spouse are no longer married or legally terminate Your relationship;

unless continued in accordance with one of the Continuation Provisions or Extended Continuation as shown below.

Extended Continuation: If Your or Your Dependent(s) coverage ends under this Certificate due to a Qualifying Event, You will be able to elect to continue coverage under this Policy subject the terms and limitations of the Policy, without interruption with respect to all benefits and periods.

The amount of continued coverage applicable to You or Your Dependent(s) will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:
1) is subject to any reductions in the Policy;
2) is subject to Your or Your Dependent(s) continued payment of premium; and
3) terminates on the earliest of:
   a) the date The Policy terminates;
   b) the last day of the period the required premium is due but unpaid;
   c) the date You or Your Dependent(s) request in writing to Us; or
   d) 5 year(s) from the date the continuation commenced.

The amount of insurance will not change while coverage is being continued. You may not apply this continuation concurrently with any of the other Continuation Provisions in the Policy.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

You or Your Dependent(s) may elect this continuation if Your Critical Illness insurance ends due to a Qualifying Event. The Policy must still be in force for Extended Continuation to be available.

To elect Extended Continuation, You or Your Dependent(s) must send a written request to Us. This must be received within 31 days after Critical Illness insurance terminates and will become effective on the day following the date Your or Your Dependent(s) coverage ends, such that there is no interruption in coverage. Upon receipt of Your or Your Dependent(s) written request, we will provide notification of premiums required and the schedule in which such premiums are due. You or Your Dependent(s) will be responsible for the direct payment of premium.

CONTINUATION PROVISIONS

Continuation:
Coverage may be continued, at the Policyholder's option beyond a date shown in the Termination of Primary Insured's Coverage provision, if the Policyholder provides a plan of continuation which applies to all employees the same way.

Coverage for Your Dependents will continue if Your coverage is continued.

The amount of continued coverage applicable to You or Your Dependent will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

1) is subject to any reductions in the Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if the Policy terminates.

The amount of insurance will not increase while coverage is being continued. The Continuation Provisions shown below will not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent coverage) may be continued for 12 month(s) following the date on which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You or Your Dependent enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent coverage) may be continued for up to 12 month(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, Your coverage (including Dependent coverage) may be continued:

1) for a period of 365 consecutive day(s) from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 365 consecutive day(s).

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

CRITICAL ILLNESS BENEFITS

Critical Illness Benefit:
If a Covered Person is Diagnosed with a Critical Illness, while covered under the Policy, We will pay a Critical Illness Benefit. The Critical Illness Benefit is equal to the Coverage Amount multiplied by the Percentage of Coverage Amount for the Critical Illness, as shown in the Benefit Schedule for each Covered Person.

Subject to the Coverage Maximums shown in the Benefit Schedule:

1) Cancer Benefits shown in the Benefit Schedule will only be paid once for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Cancer Benefit or a Cancer Recurrence Benefit, a period of 3 months must be satisfied before payment of any other Cancer Benefit;
2) Vascular Benefits shown in the Benefit Schedule will only be paid once for each Covered Person, unless a Recurrence Benefit is available. Following payment of a Vascular Benefit or a Vascular Recurrence Benefit, a period of 3 months must be satisfied before payment of any other Vascular Benefit; and
3) with the exception of Vascular and Cancer Benefits, there is no period of time to be satisfied before payment of any other Critical Illness Benefit.

Recurrence Benefit:
We will pay a Recurrence Benefit as shown in the Benefit Schedule if a Covered Person receives a Diagnosis of a recurrence of a Critical Illness previously paid under the Policy.

Subject to the Coverage Maximums shown in the Benefit Schedule:

1) the condition must be listed as a Recurrence Benefit in the Benefit Schedule; and
2) the Diagnosis of recurrence must be made 1 months or more following the initial Critical Illness Diagnosis.

We will not pay more than one Recurrence Benefit per Critical Illness for the Covered Person during the Covered Person's lifetime.

Health Screening Benefit:
For each day a Covered Person has one or more of the screening tests for Critical Illness listed below, not to exceed one day per calendar year, We will pay the Health Screening Benefit stated in the Schedule. The amount stated is the total amount payable in any calendar year regardless of the number of tests or days of tests during that calendar year.

1) bone marrow testing;
2) CA15-e (cancer antigen 15-3 blood test for breast cancer);
3) CA125 (cancer antigen 125 blood test for ovarian cancer);
4) CEA (carcinoembryonic antigen blood test for colon cancer);
5) chest x-ray;
6) colonoscopy;
7) flexible sigmoidoscopy;
8) hemocult stool analysis;
9) mammography; including breast ultrasound;
10) Pap smear; including ThinPrep Pap Test;
11) PSA (prostate specific antigen blood test for prostate cancer);
12) Serum Protein Electrophoresis (test for myeloma);
13) Biopsy for Skin Cancer;
14) Blood test for triglycerides;
15) HPV (Human Papillomavirus) Vaccination;
16) lipid panel (total cholesterol count);
17) doppler screening for carotids;
18) doppler screening for peripheral vascular disease;
19) thermography;
20) echocardiogram;
21) ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
22) EKG;
23) stress test on bike or treadmill;
24) fasting blood glucose test;
25) serum cholesterol to determine level of HDL and LDL; or
26) COVID-19 testing when performed by an appropriately licensed medical professional.

We will pay:

1) regardless of the result of any test; and
2) provided the test was conducted while the Covered Person was covered under the Policy.

LIMITATIONS AND EXCLUSIONS

Pre-existing Condition Limitation:
We will not pay any benefit, or any increase in benefits, under the Policy for any Critical Illness that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time the Covered Person is Diagnosed with the Critical Illness, the Covered Person has been continuously insured under the Policy for .

If the Covered Person becomes insured under the Policy on the Policy Effective Date and was covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

1) the Policy Effective Date, if the Covered Person's coverage for Critical Illness insurance was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force.

The Pre-existing Condition Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from:

1) a change in coverage for which You elect; or
2) a change from the Prior Policy to the Policy.

Pre-existing Condition means:

1) any Critical Illness; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such Critical Illness;

for which the Covered Person received Medical Care during the period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

In no event will We consider an annual or routine medical examination, test, attendance, observation or screening to be treatment unless it indicates the presence of a Critical Illness or leads to follow up examinations, tests, attendance, observation or screening which results in the Diagnosis of a Critical Illness.

All manifestations, symptoms, or findings which result:

1) from the same or related Critical Illness; or
2) from any aggravations of a Critical Illness;

are considered to be the same Critical Illness for the purpose of determining a Pre-Existing Condition.

Medical Care is received when a Physician:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides treatment.

Exclusions:
No benefits are payable under this Certificate for Critical Illness that results from or is caused by:

1) suicide, attempted suicide or intentionally self-inflicted injury, whether sane or insane;
2) war or act of war, declared or undeclared, not including acts of terrorism;
3) the Covered Person's participation in a felony, riot or insurrection;
4) the Covered Person's engaging in any illegal occupation; or
5) the Covered Person's service in the armed forces or units auxiliary to them.

CLAIM PROVISIONS

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

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

Proof of Loss:
The claimant must send written proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of

loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

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

Payment of Claims:
All payments are payable to You. Any payments owed at Your death may be paid to Your estate in a lump sum.

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

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

Claim Appeal:
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so he or she:

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

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

Overpayment Recovery:
We have the right to recover from the Primary Insured any amount that We determine to be an overpayment. The Primary Insured has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, the Primary Insured must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) the Primary Insured;
   b) any other person to or for whom payment was made; and
   c) the Primary Insured's estate;
2) reduce or offset against any future benefits payable to the Primary Insured or his/her survivors until full reimbursement is made;
3) refer the Primary Insured's unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

GENERAL PROVISIONS

Statements:
In the absence of fraud, all statements made by the Policyholder or any Covered Person will be considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or personal representative.

Time Limit on Certain Defenses:
After a Covered Person has been insured under the Policy for 2 years during his or her lifetime, no statement made by a Covered Person, except fraudulent misstatements, will be used to reduce or deny a claim beginning after the 2 year period. In order to be used, the statement must be in writing and signed by You and Your Spouse.

Legal Actions:
No legal action may start:

1) until 60 days after proof of loss has been given;
2) more than 5 years after the time proof of loss is required to be given.

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

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

Policy Interpretation:
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. This provision applies where the interpretation of the Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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

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

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

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

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Amendatory Rider

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155

For questions or complaints, please contact Us at 1-800-523-2233

(A stock insurance company)

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

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

This rider becomes effective on February 1, 2026.

With respect to All Full-time and Part-time Active Employees, Your Certificate is amended as follows:

1. The following **Non-Melanoma Skin Cancer** benefit shall be included under **Cancer Benefits** in the **Benefit Schedule** section of Your Certificate:

Non-Melanoma Skin Cancer	$250 once per lifetime for each Covered Person

2. The following **Advanced Alzheimer's Disease** benefit shall be included under **Neurological Benefits** in the **Benefit Schedule** section of Your Certificate:

Advanced Alzheimer's Disease	100%

3. The following **Advanced Alzheimer's Disease** definition shall be included in the **Definitions** section of Your Certificate:

   Advanced Alzheimer's Disease means a condition Diagnosed as Alzheimer's disease that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST). Diagnosis must be made by a Physician who is a board-certified neurologist, and must be supported by neurological examination and cognitive testing for the involved condition/illness. There must be permanent clinical loss of the ability to do all of the following:
   1) remember, reason, and perceive; and
   2) understand, express and give effect to ideas.

   Other types of dementia are not included in this definition. The initial Diagnosis of Alzheimer's disease must occur while the Covered Person is insured under the Policy.

4. The following **Confined, Confinement** definition shall be included in the **Definitions** section of Your Certificate:

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

5. The following **Confined Elsewhere** definition shall be included in the **Definitions** section of Your Certificate:

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

6. The definition of **Critical Illness** shown in the **Definitions** section of Your Certificate is amended to read as follows:

Critical Illness means any of the conditions shown in the Benefit Schedule for which a Covered Person is Diagnosed after the effective date of coverage under the Policy for the Covered Person. This definition does not include the recurrence of an Invasive Cancer or Non-Invasive Cancer that was Diagnosed before the effective date of insurance for a Covered Person unless, after the previous Diagnosis and before the date of the subsequent Diagnosis, We receive medical evidence that the Covered Person is considered to be in complete remission with no evidence of disease (NED) for the previous Diagnosis.

7. The definition of **Diagnosis** shown in the **Definitions** section of Your Certificate is amended to read as follows:

   Diagnosed, Diagnosis means the definitive establishment of a Critical Illness through the use of clinical or pathological findings. We will accept a clinical Diagnosis only if a pathological Diagnosis cannot be made. The Diagnosis must be made by a Physician who is a board certified specialist where required in the Policy.

   The date of Diagnosis under the Policy 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.

8. The following **Non-Melanoma Skin Cancer** definition shall be included in the **Definitions** section of Your Certificate:

   Non-Melanoma Skin Cancer means basal cell carcinoma and squamous cell carcinoma. Actinic keratosis is not included in this definition.

9. The following **Deferred Coverage Effective Date** provision shall be included in the **Eligibility and Effective Dates** section of Your Certificate:

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

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

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

   This provision does not apply to:
   1) Employees who are currently eligible for coverage under the Continuity from a Prior Policy provision;
   2) any Dependent who was eligible and insured under the Prior Policy on the day before the Policy Effective Date, except when coverage is being reinstated; or
   3) any disabled child who qualifies under the definition of Dependent Child(ren).

10. The **Changes in Coverage** provision shown in the **Eligibility and Effective Dates** section of Your Certificate is amended to read as follows:

    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) elect, increase, decrease, drop or otherwise change coverage within 60 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 first of the month following 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.

11. The **Newborn and Newly Adopted Child Coverage** provision shown in the **Eligibility and Effective Dates** section of Your Certificate is removed in its entirety and replaced with the following:

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 60 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 60 day period.

12. The following **Reinstatement of Coverage** section shall be included in Your Certificate, immediately following the **Termination of Insurance** section:

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:
1) the Employee returns to an Eligible Class for Coverage within 12 months from the date coverage ended; and
2) reinstatement is requested within 31 days from his/her return to an Eligible Class for Coverage, 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.

We will credit any time the Employee and any Dependent(s) were previously insured under the Policy toward the satisfaction of the Waiting Period.

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

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. 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.

13. The **Critical Illness Benefit** provision shown in the **Critical Illness Benefits** section of Your Certificate is amended to read as follows:

Critical Illness Benefit:
If a Covered Person is Diagnosed with a Critical Illness while covered under the Policy, We will pay a Critical Illness Benefit. The Critical Illness Benefit is equal to the Coverage Amount multiplied by the Percentage of Coverage Amount for the Critical Illness, as shown in the Benefit Schedule for each Covered Person.

Subject to the Coverage Maximums shown in the Benefit Schedule, each benefit shown in the Benefit Schedule will be paid once for each Covered Person, unless a Recurrence Benefit is available. After the Diagnosis of a Critical Illness for which benefits are paid under the Policy, We will pay benefits for the Diagnosis of each subsequent, different Critical Illness under the Policy subject to the following:
1) the date of Diagnosis for the new Critical Illness is separated from the date of Diagnosis for the prior, different Critical Illness by at least 3 months; and

2) the new Critical Illness is not caused or affected by a Critical Illness for which benefits have previously been paid under the Policy.

The 3 month separation period noted above applies to the Diagnosis of any Critical Illness with a Percentage of Coverage Amount of 100%. Following the Diagnosis of any Critical Illness with a Percentage of Coverage Amount of 25% or 50%, there is no period of time to be satisfied before Diagnosis of any other Critical Illness.

14. The **Pre-existing Condition Limitation** provision shown in the **Limitations and Exclusions** section of Your Certificate will no longer apply, and is removed in its entirety.

15. The **Payment of Claims** provision shown in the **Claim Provisions** section of Your Certificate is amended to read as follows:

Payment of Claims:
All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:
1) Your designated beneficiary(ies); or if none, then to
2) Your estate.

Where required by law, benefits paid on behalf of a Covered Person under this Certificate shall be paid to the applicable human services department when:
1) the human services department has paid or is paying benefits on behalf of the Covered Person under a state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
2) payment for the services in question has been made by the human services department to a Medicaid provider; and
3) We are notified that the Covered Person receives benefits under the Medicaid program.

16. The following **Beneficiary Designation** and **Change of Beneficiary** provisions shall be included in the **Claim Provisions** section of Your Certificate following the **Payment of Claims** provision:

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. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

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

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

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

In all other respects the Certificate remains the same.

Signed for Hartford Life and Accident Insurance Company

Kevin Barnett, *Secretary*

Michael J. Fish, ***Head of Group Benefits***

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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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hartford's Duties

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

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

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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

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

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

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1. **Plan Name**

   For employees of THE HERTZ CORPORATION:

   Group Critical Illness Plan

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2. **Plan Number**

   Group Critical Illness - 505

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3. **Employer/Plan Sponsor**

   THE HERTZ CORPORATION
   8501 WILLIAMS ROAD
   ESTERO, FL 33928

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4. **Employer Identification Number**

   13-1938568

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Critical Illness Insurance

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6. **Plan Administrator**

   THE HERTZ CORPORATION
   8501 WILLIAMS ROAD
   ESTERO, FL 33928

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

   For the Plan

   THE HERTZ CORPORATION

8501 WILLIAMS ROAD
ESTERO, FL 33928

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions**

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

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

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

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

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

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

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

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

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request.

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

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

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

Claim Procedures for Claims Not Requiring a Determination of Disability

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

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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