YOUR BENEFIT PLAN

NIAGARA BOTTLING LLC

Accident

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 https://www.thehartford.com/. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us or one of our contracted administrators 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.

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 domestic partners, civil unions, and any other legal union recognized 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. **For Your Questions and Complaints:**
   Arkansas Insurance Department
   Consumer Services Division
   1200 West Third Street
   Little Rock, AR 72201-1904
   Toll Free: 1(800) 852-5494
   Local: 1(501) 371-2640

California:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section 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:

(a) 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 Notice of Claim, 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;
(b) 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;
(c) 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;
(d) 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.

2. **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. Reference to fraud in the **Statements** provision, located in the **General Provisions** section, is not applicable.
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.

Florida:

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

Idaho:

1. **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. The **Policy Interpretation** provision**,** if shown in the **General Provisions** section, is not applicable.
2. **For Your Questions and Complaints**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, IL 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
   Web Address: http://insurance.illinois.gov/
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
2. The term CONTRACT is replaced with CERTIFICATE in Medicare Supplement **NOTICE** found on the first page of the Certificate.

Kansas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section, does not apply to you. 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 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:
   (a) Your coverage terminates because You enter active military service; and
   (b) 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:
   (a) be the same coverage amounts in force on the date coverage terminated; and
   (b) not be subject to any Waiting Period for Coverage; and
   (c) be subject to all the terms and provisions of the Policy.

Maine:

1. **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.

Minnesota:

1. **Notice of Claim,** as shown in the **Claim Provisions** section, should be sent to:
   WebTPA, Inc.
   P.O. Box 99906
   Grapevine, TX 76099.
2. Payment of claim will occur immediately after Our receipt of due written Proof of Loss, regardless of what is stated in the **Time of Payment of Claims,** located in the **Claim Provisions** section of the certificate.

Missouri:

1. The term CONTRACT is replaced with CERTIFICATE in the Medicare Supplement **NOTICE** found on the first page of the Certificate.

New Hampshire:

1. Reference to fraud in the **Statements** provision located in the **General Provisions** section, is not applicable.
2. If it is not reasonably possible to give proof during the time period referenced in the **Proof of Loss** provision, located in the **Claim Provisions** section, then proof must be provided as soon as reasonably possible.
3. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
4. 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.

New Mexico:

1. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
2. Benefits paid on behalf of a Covered Person under this certificate shall be paid to the Human Services Department when:
   a. 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
   b. payment for the services in question has been made by the Human Services Department to the Medicaid provider; and
   c. 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.
3. **NOTICE:** If you are covered under a Non-ERISA policy issued outside of New Mexico, the following notice applies to you:

Consumer Complaint Notice

If you are resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding your claim, premium, or other matters pertaining to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/

New York:

1. **NOTICE:** The insurance evidenced by this certificate provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

North Carolina:

1. **Notice of Claim,** as shown in the **Claim Provisions** section, should be sent to:
   WebTPA, Inc.
   P.O. Box 99906
   Grapevine, TX 76099.
2. Payment of claim will occur immediately after Our receipt of due written Proof of Loss, regardless of what is stated in the **Time of Payment of Claims**, located in the **Claim Provisions** section of the certificate.
3. **Proof of Loss,** as shown in the **Claim Provisions** section, must be provided within 180 days from the date of loss.
4. Reference to fraud in **Time Limit on Certain Defenses** provision, located in the **General Provisions** section, is not applicable.

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. The following continuation requirement applies to you:
   Family Military Leave of Absence: If Your spouse or child enters active full-time military service outside of the continental United States, Hawaii, Puerto Rico or Alaska, and You:
   a) have been employed with the same employer for at least two years; and
   b) have completed 1,250 hours of service during a 12 month period immediately prior to the date Military Leave of Absence would begin; and
   c) have exhausted all the other time made available to You by Your Employer except sick time and short term disability;

   then Your coverage may be continued for up to 30 days. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

   To elect a Family Military Leave of Absence, You must notify Your Employer at least 14 days prior to the date the leave would begin if the leave would consist of five or more consecutive work days. For a leave of less than five days, the Employee should give notice as soon as reasonable possible.

South Dakota:

1. 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. **IMPORTANT NOTICE**

   To obtain information or make a complaint:

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

   1-800-523-2233

   You may also write to The Hartford at:

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

   You may contact the Texas Department of Insurance to obtain information on companies,

   AVISO IMPORTANTE

   Para obtener información o para presentar una queja:

   Usted puede llamar al número de teléfono gratuito de The Hartford's para obtener información o para presentar una queja al:

   1-800-523-2233

   Usted también puede escribir a The Hartford:

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

   Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre

coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

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

PREMIUM OR CLAIM DISPUTES:

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

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

compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

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

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

Virginia:

1. **For Your Questions and Complaints:**
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23209
   1(804) 371-9741 (inside Virginia)
   1(800) 552-7945 (outside Virginia)

Washington:

1. **Accident Benefits** and **Accidental Death and Dismemberment Benefits** or covered expenses incurred because of an accidental injury shall be paid if the covered death occurs, or the covered services are incurred, within one year of the accident.

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 (outside of Madison)
   1(608) 266-0103 (in Madison)

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

Will pay benefits according to the conditions of the Policy.

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

Policyholder:	NIAGARA BOTTLING LLC
Policy Number:	VAC-804772
Policy Issue State:	California

READ THIS CERTIFICATE CAREFULLY.

Hartford Life and Accident Insurance Company has issued and delivered a group insurance policy to the Policyholder shown above. This Certificate describes Accident insurance provided to Covered Persons under the Policy issued to the Policyholder.

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

Lisa Levin, *Secretary*

Jonathan Bennett, *President*

Notice to Buyer: The Policy provides Accident-only coverage and it does not pay benefits for loss from sickness. Review Your Certificate carefully.

The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

This Policy may provide payment of several benefits as a result of claims from a single Accident. Payment of one benefit for an Accident under this Policy does not constitute acceptance of liability for all claims made under the Policy nor does it prohibit Us from further investigation into the cause of or existence of an Accident for subsequent claims.

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 the Company.

GROUP ACCIDENT INSURANCE CERTIFICATE
Non-Participating

RIGHT TO RETURN THIS CERTIFICATE. IF, FOR ANY REASON, YOU ARE NOT SATISFIED WITH THIS CERTIFICATE, YOU CAN RETURN IT TO US AT OUR HOME OFFICE WITHIN 30 DAYS AFTER YOU RECEIVED IT. AT THAT TIME, YOU SHOULD ASK US IN WRITING TO CANCEL IT. WE WILL CONSIDER THIS CERTIFICATE AS IF IT NEVER EXISTED. ANY PREMIUM PAID WILL BE REFUNDED.

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

Policy Effective Date: January 1, 2020

Eligible Classes for Coverage: All Full-time Active Employees scheduled to work at least 30 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: 30 days

Plan Type: Accident

Accident Type: Off the Job Coverage

Policy Age Limit: 80

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

ACCIDENT BENEFITS

Description of Benefit	Benefit Amount
Accident Follow-Up Benefit	$75
Acupuncture Benefit	$25
Ambulance (Air) Benefit	$1,500
Ambulance (Ground) Benefit	$300
Blood/Plasma/Platelet Benefit	$300
Child Care Benefit	$25 per day
• Maximum Daily Benefit	$100 per day
Chiropractic Care Benefit	$25
Daily Hospital Confinement Benefit	$200 per day
Daily ICU Confinement Benefit	$400 per day
Diagnostic Exam Benefit	$200
Emergency Dental Benefit (extraction)	$100
Emergency Dental Benefit (crown)	$300
Emergency Room Benefit	$150
Hospital Admission Benefit	$1,000
Initial Physician Visit Benefit	$100
Lodging Benefit	$125 per day
Medical Appliance Benefit	$100
Physical Therapy Benefit	$25 per day
Rehabilitation Facility Benefit	$100 per day
Transportation Benefit	$300 per trip
Urgent Care Benefit	$75
X-Ray Benefit	$50
Dislocations Benefit (open reduction)	
• Hip	$4,000
• Knee (except patella)	$2,000
• Ankle - bone/bones of the foot (other than toes)	$1,000
• Collarbone (sternoclavicular)	$1,000
• Lower jaw	$1,000
• Shoulder (glenohumeral)	$1,000
• Elbow	$1,000
• Wrist	$1,000
• Bone/bones of the hand (other than fingers)	$1,000
• Collarbone (acromioclavicular and separation)	$500
• One toe or finger	$200
Dislocations Benefit (closed reduction)	
• Hip	$2,000
• Knee (except patella)	$1,000
• Ankle - bone/bones of the foot (other than toes)	$500
• Collarbone (sternoclavicular)	$500
• Lower jaw	$500
• Shoulder (glenohumeral)	$500
• Elbow	$500
• Wrist	$500
• Bone/bones of the hand (other than fingers)	$500
• Collarbone (acromioclavicular and separation)	$250
• One toe or finger	$100
Dislocations Benefit (incomplete)	25% of the Dislocations Benefit (closed reduction)
Fractures Benefit (open reduction)	
• Skull (except bones of face or nose)	
• Depressed skull fracture	$6,000
• Simple non- depressed skull fracture	$6,000
• Hip, thigh (femur)	$4,000
• Vertebrae, body of (excluding vertebral processes)	$1,500

Description of Benefit	Benefit Amount
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	$1,500
• Leg (tibia and/or fibula)	$1,500
• Bones of face or nose (except mandible or maxilla)	$800
• Upper jaw, maxilla (except alveolar process)	$1,000
• Upper arm between elbow and shoulder (humerus)	$1,000
• Lower jaw, mandible (except alveolar process)	$1,000
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	$1,000
• Vertebral processes	$800
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	$1,000
• Kneecap (patella)	$1,000
• Foot (except toes)	$1,000
• Ankle	$1,000
• Rib	$400
• Coccyx	$400
• Finger, toe	$300
Fractures Benefit (closed reduction)	
• Skull (except bones of face or nose)	
• Depressed skull fracture	$3,000
• Simple non- depressed skull fracture	$3,000
• Hip, thigh (femur)	$2,000
• Vertebrae, body of (excluding vertebral processes)	$750
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	$750
• Leg (tibia and/or fibula)	$750
• Bones of face or nose (except mandible or maxilla)	$400
• Upper jaw, maxilla (except alveolar process)	$500
• Upper arm between elbow and shoulder (humerus)	$500
• Lower jaw, mandible (except alveolar process)	$500
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	$500
• Vertebral processes	$400
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	$500
• Kneecap (patella)	$500
• Foot (except toes)	$500
• Ankle	$500
• Rib	$200
• Coccyx	$200
• Finger, toe	$150
Chip Fracture	25% of Fractures Benefit (closed reduction)
Abdominal/Thoracic Surgery Benefit	$1,500
Arthroscopic Surgery Benefit	$300
Burn Benefit	
• Second Degree Burns	$1,000
• Third Degree Burns	$10,000
Skin Graft Benefit	25% of applicable burn benefit
Concussion Benefit	$150
Eye Injury Benefit surgical repair	$400
Eye Injury Benefit removal of foreign object	$200
Hernia Benefit	$150
Joint Replacement Benefit	$2,000

Description of Benefit	Benefit Amount
Knee Cartilage Benefit (with repair)	$750
Knee Cartilage Benefit (without repair)	$150
Lacerations Benefit	
• 2" to 6" with sutures	$300
• Greater than 6" with sutures	$600
Ruptured Disc Benefit	$750
Tendon/Ligament/Rotator Cuff Benefit	
• Single	$800
• Two or more	$1,000
Coma Benefit	$10,000
Prosthesis Benefit	
• Single	$750
• Two or more	$1,500

DEFINITIONS

Accident means a sudden, unforeseeable event that causes an Injury and that:
(a) occurs while this Certificate is in force;
(b) occurs while the Covered Person's insurance is effective; and
(c) is not subject to any exclusion in the Policy.

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 perform all the regular duties of Your job in the usual way and 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.

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

Certificate means this document, which provides a summary of 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:
(a) You get married or enter into a legal relationship recognized as a spouse;
(b) You and Your spouse divorce or legally terminate Your relationship;
(c) Your child is born or You adopt, You receive a step child or become the legal guardian of a child;
(d) Your spouse dies;
(e) Your child is no longer a Dependent Child or dies;
(f) Your spouse is no longer employed, which results in a loss of accident insurance sponsored by the Spouse's employer; or
(g) You have a change in classification from part-time to full-time or from full-time to part-time.

Child Care Services means a child supervision services facility which:
(a) is operated in a private home, school or other facility;
(b) provides, and makes a charge for, the care of children; and
(c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Child Care Services includes child care provided in the Primary Insured's or Spouse's home by a licensed child care provider, if such licensing is required by the state or jurisdiction in which it is located. If such licensing is not required, care in the home must be provided by an individual who offers professional child care services for a fee.

Child Care Services will not include child care which is provided by a Family Member of the child receiving the care.

Chip Fracture means an Injury where small fragments of bone are chipped from the bones main structure. These are also known as avulsion fractures.

Coma means complete unconsciousness with inability to respond to external or internal stimuli for a continuous period of at least 168 hours. The diagnosis of a Coma must be made by a Physician.

Concussion means a traumatic brain injury resulting in immediate and transient alteration in brain function, including alteration of mental status and level of consciousness.

Confined or Confinement means being an Inpatient in a medical facility for a period of at least 1 day due to an Injury sustained in an Accident.

Confined Elsewhere means You are unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Covered Person means the Primary Insured and all Dependents.

Day Care or Day Care Program means a program of child care which:

(a) is operated in a private home, school or other facility;
(b) provides, and makes a charge for, the care of children; and
(c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Day Care does not include care which is provided by a Family Member of the child receiving the care.

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

Dependent Child(ren) means Your or Your Spouse's natural children, step-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 an unmarried child is age 26 or older and is:

(a) incapable of self-sustaining employment because of a mental 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 for as long as these conditions exist.

Dislocation means a completely separated joint.

(a) open reduction of Dislocation means a surgical procedure.
(b) closed reduction of Dislocation means a non-surgical procedure.

Dismemberment means the total and irrevocable loss of any of the losses referenced in the Benefit Schedule.

Emergency Room means a specified area within a Hospital that is designated for the emergency care of accidental injuries. This area must:

(a) be staffed and equipped to handle trauma;
(b) be supervised and provide treatment by Physicians; and
(c) provide 24 hours a day service by registered graduate nurses (RNs).

Extended Care Facility means a place which:

(a) is licensed by the state in which it is located;
(b) provides nursing home care on an inpatient basis under the supervision of a Physician;
(c) has nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN), or licensed practical nurse (LPN);
(d) keeps a daily medical record of each patient; and
(e) is either a freestanding facility or a ward, wing, or swing bed of a Hospital or other institution.

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

Follow-Up Treatment means consultation, care or services provided by a Physician for Injuries incurred from an Accident. Follow-Up Treatment must occur after initial treatment by a Physician or in an Emergency Room for Injuries due to the same Accident.

Fracture means a broken bone which can be seen by x-ray.

(a) open reduction of fracture means a surgical procedure.
(b) closed reduction of fracture means a non-surgical procedure.

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

Hospital means an institution:

(a) licensed to operate as a Hospital pursuant to law;
(b) primarily and continuously engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
(c) providing twenty-four hour nursing service by or under the supervision of registered nurses.

Hospital does not include:
(a) convalescent homes, or convalescent, rest or nursing facilities;
(b) facilities affording primarily custodial, educational or rehabilitory care; or
(c) facilities for the aged, drug addicts or alcoholics.

Injury or Injuries means bodily injury sustained by a Covered Person that is the direct result of an Accident, and is independent of disease or bodily infirmity or any other cause.

Inpatient means treatment received by the Covered Person as a resident patient using and being charged for the room and board facilities of a Hospital.

Intensive Care Unit (ICU) means a specifically designated part of a Hospital called an intensive care unit as listed in the most current American Hospital Association Guide that:
(a) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care. An Intensive Care Unit includes a neonatal intensive care unit specializing in the care of ill or premature newborn infants;
(b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
(c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
(d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis; and
(e) has an assigned Physician on a full-time basis.

An Intensive Care Unit is not any of the following step-down units:
(a) a progressive care unit;
(b) an intermediate care unit;
(c) a private monitored room;
(d) sub-acute intensive care unit; or
(e) an Observation Unit.

Laceration means a cut of at least 2 inches in length requiring sutures.

Medical Appliance means a walking boot that extends above the ankle, brace for the neck, back, knee or leg, cane, crutches, walker and wheelchair.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient surgery or treatment in the Emergency Room by a Physician and which:
(a) is under the direct supervision of a Physician or registered nurse;
(b) is staffed by nurses assigned specifically to that unit; and
(c) provides care seven days per week, 24 hours per day.

Off the Job Coverage means coverage is provided under the Policy for Injuries resulting from an Accident that occurs while the Primary Insured is not working for pay or profit.

Outpatient means treatment received by the Covered Person at a Hospital or licensed ambulatory care facility and there is no charge for room and board.

Physician means a person who is:
(a) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art that We recognize or are required by law to recognize;
(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 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 Accident 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:

(a) non-payment of premium; or
(b) 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.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients disabled by accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The rehabilitation unit may be part of a Hospital or a freestanding facility.

A rehabilitation unit is not:

(a) a nursing home;
(b) an Extended Care Facility;
(c) a skilled nursing facility;
(d) a rest home or home for the aged;
(e) a hospice care facility;
(f) a place for alcoholics or drug addicts; or
(g) an assisted living facility.

Second Degree Burn means a burn in which damage penetrates into some of the underlying layers of skin.

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 with a government agency or office where such registration is available, or other relationship allowed by state law.

For residents of states that do not offer domestic partner registration: Spouse will include Your affidavit domestic partner provided You have executed a complete domestic partner affidavit, establishing that You and Your partner are domestic partners for purposes of the Policy. You will continue to be considered affidavit domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Third Degree Burn means a burn which extends to all layers of skin.

Urgent Care Facility means a facility or place other than a Physician's office, Hospital, or an Emergency Room that provides emergency or urgent care and treatment to injured people. Such facility may be a 24-hour clinic.

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:

(a) the Policy Effective Date;
(b) the date You become a member of an Eligible Class for Coverage; or
(c) the date You complete the Waiting Period.

The Waiting Period will be reduced by the period of time You were a Full-Time Active Employee with the Policyholder under the Prior Policy.

Dependent Eligibility for Coverage: Your Dependent(s) will become eligible for coverage on the later of:

(a) the date You become insured for employee coverage; or
(b) 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 Active Employee under the Policy.

Enrollment:

To enroll, You must:

(a) complete and sign a group insurance enrollment form for Your coverage and Your Dependent's coverage within 30 days of the date You are eligible for coverage; and
(b) deliver it to the Policyholder.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 30 days after becoming eligible under the Policy, and later choose to enroll, You may only enroll for Your coverage and/or Your Dependent's coverage:

(a) during an Annual Enrollment Period designated by the Policyholder; or
(b) within 30 days of the date You have a Change in Family Status.

Primary Insured's Coverage Effective Date:

Your coverage will start on the later to occur of:

(a) the first of the month on or next following the date You become eligible;
(b) 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;
(c) the first of the month on or next following the date You enroll, if You do so within 30 days from the date You are eligible.

All effective dates of coverage are subject to the Deferred Coverage Effective Date provision.

Continuity from a Prior Policy:

Accident coverage under this Certificate will begin, and will not be deferred if, on the day before the Effective Date for Coverage, You were:

(a) insured under the Prior Policy; and
(b) Actively at Work or on an authorized family and medical leave;

but on the Effective Date for Coverage, You were not Actively at Work, but would otherwise meet the eligibility requirements of the Policy.

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

(a) the last day of a period of 12 consecutive months after the Effective Date for Coverage;
(b) the date Your insurance terminates for any reason shown under the Termination of Primary Insured's Coverage provision;
(c) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
(d) 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.

Deferred Coverage Effective Date: Your Effective Date for Coverage will be delayed if You are not Actively at Work due to physical or mental condition on the Effective Date for Coverage shown on the Benefit Schedule. Coverage will become effective on the date You are Actively at Work.

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

(a) the first of the month on or next following the date Your Dependent becomes eligible for Dependent coverage, if You have enrolled on or before that date; or
(b) 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; or
(c) the first of the month on or next following the date You enroll, if You do so within 30 days from the date You are eligible for Dependent coverage.

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

Deferred Coverage Effective Date for Dependents: If, on the date Your Dependent, is to become covered under the Policy:

(a) on the Effective Date for Coverage; or
(b) for increased benefits; or
(c) for a new benefit; and

he or she is:

(a) confined; or
(b) Confined Elsewhere;

such coverage will not start until he or she:

(a) is discharged from the Hospital; or
(b) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender in good health, for at least 15 consecutive days.

Newlywed Coverage: If You marry while covered under the Policy, Your Spouse shall automatically become covered under the Policy for 30 days after the date of marriage. Benefits and amounts will be the minimum amount for those We are providing for Spouse coverage under the Policy at that time.

Coverage of Your Spouse will cease after 30 days from the date of marriage unless You:

(a) request in writing that coverage for Your Spouse be continued; and
(b) pay the additional required premium.

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

(a) have a newborn child; or
(b) adopt or receive a stepchild;

the child will become covered under the Policy for 30 days after the date of birth or placement with You. 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 30 days from the date of birth or financial dependence unless You:

(a) request in writing that coverage for Your child be continued; and
(b) pay the additional required premium.

TERMINATION OF INSURANCE

Termination of Primary Insured's Coverage: Your coverage will end on the earliest of the following:

(a) the date the Policy terminates;
(b) 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;
(c) the date the required premium is due but not paid, subject to the individual grace period;
(d) the last day of the month following the date You request We terminate Your coverage;
(e) the last day of the month following the date the Policyholder terminates Your employment;
(f) the last day of the month following the date You are no longer Actively at Work; or
(g) the Policy anniversary following the date You attain the Policy Age Limit as shown in the Benefit Schedule;

unless continued in accordance with one of the Continuation Provisions.

Termination of Dependent Coverage: Coverage for Your Dependent(s) will end on the earliest to occur of:

(a) the date Your coverage ends;
(b) the date the required premium is due but not paid, subject to the individual grace period;
(c) the last day of the month following the date You are no longer eligible for Dependent coverage;
(d) the last day of the month following the date We or the Policyholder terminate Dependent coverage;
(e) the last day of the month following the date You request We terminate Dependent coverage;
(f) the last day of the month following the date the child no longer meets the definition of Dependent Child; or
(g) the last day of the month following the date that You and Your Spouse are no longer married;

unless continued in accordance with one of the Continuation Provisions.

CONTINUATION PROVISIONS

Continuation: Coverage may be continued, at the Policyholder's option beyond a date shown in the Termination 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:

(a) is subject to any reductions in the Policy;
(b) is subject to payment of premium;
(c) may be continued up to the maximum time shown in the provisions; and
(d) terminates if:
    1) the Policy terminates; or
    2) You attain age 80.

The amount of insurance will not increase while coverage is being continued. The Continuation Provisions shown below may 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 365 days following the last day of the month in 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 Dependents 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 52 weeks. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Status Change: If You are:

(a) employed by the Policyholder; and
(b) no longer in an Eligible Class due to a reduction in the number of scheduled hours You work;

Your coverage (including Dependent coverage) may be continued until the last day of the third consecutive month after the date Your scheduled hours were reduced.

Disability Insurance: If You:

(a) are covered by; and
(b) are approved for benefits under; and
(c) meet the definition of disabled under;

a group disability insurance policy, issued by Us to the Policyholder, Your coverage (including Dependent coverage) may be continued for a period of up to 12 consecutive month(s) from the date You were last Actively at Work while You remain disabled.

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

(a) for a period of 12 months from the date You were last Actively at Work; or
(b) 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 12 months.

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.

ACCIDENT BENEFITS

Accident Follow-Up Benefit: We will pay the Accident Follow-Up Benefit Amount shown in the Benefit Schedule for each day a Covered Person receives Follow-Up Treatment for Injuries sustained in an Accident. Treatment must be recommended or advised by a Physician. Follow-Up Treatment must be received within 90 days of the Accident. Follow-

Up Treatment does not include routine examinations or preventative testing. This Accident Follow-Up Benefit is subject to a maximum of 10 visits per Accident per Covered Person.

Acupuncture Benefit: We will pay the Acupuncture Benefit Amount shown in the Benefit Schedule if a Covered Person receives acupuncture services for treatment of an Injury sustained in an Accident. Acupuncture must be provided by a practitioner licensed as required in the state where care is provided. Acupuncture must begin within 30 days after the date of the Accident and be completed within one year of the date of Accident. No more than 10 Acupuncture Benefits are payable per Accident per Covered Person regardless of the number of acupuncture treatments received.

Ambulance (Air) Benefit: We will pay the Ambulance (Air) Benefit Amount shown in the Benefit Schedule for a licensed professional air ambulance company to transport a Covered Person to or from a Hospital, or between medical facilities for treatment of Injuries received in an Accident. The air ambulance must provide the transportation services to the Covered Person within 72 hours after the date of the Accident. One Ambulance (Air) Benefit is payable per Accident per Covered Person.

Ambulance (Ground) Benefit: We will pay the Ambulance (Ground) Benefit Amount shown in the Benefit Schedule for a licensed professional ambulance company to transport a Covered Person by ground, to or from a Hospital or between medical facilities for treatment of Injuries received in an Accident. The ambulance must provide transportation services to the Covered Person within 90 days after the date of the Accident. One Ambulance (Ground) Benefit is payable per Accident per Covered Person.

Blood/Plasma/Platelet Benefit: We will pay the Blood/Plasma/Platelet Benefit Amount shown in the Benefit Schedule if, due to an Injury sustained in an Accident, a Covered Person requires a transfusion, administration, cross matching, typing and processing of blood, plasma or platelets. The blood, plasma or platelet transfusion must be administered within 90 days of the Accident. Only one Blood/Plasma/Platelet Benefit is payable per Accident per Covered Person.

Child Care Benefit: We will pay the Child Care Benefit Amount shown in the Benefit Schedule if the Primary Insured or Spouse is confined in a Hospital due to an Accident and requires Child Care Services for children under age 16. The Benefit Amount is available for each child receiving care and shall not exceed the Maximum Daily Amount shown in the Benefit Schedule. No more than 30 days of Child Care Services are payable per Accident regardless of the number of days child care is needed. We must receive satisfactory proof that the Dependent Child is enrolled in a Day Care Program.

Chiropractic Care Benefit: We will pay the Chiropractic Care Benefit Amount shown in the Benefit Schedule if a Covered Person receives chiropractic treatment for an Injury sustained in an Accident. The chiropractor must be licensed if required in the state where care is provided. Chiropractic Care must begin within 30 days after the date of the Accident and be completed within one year of the date of Accident. No more than 10 Chiropractic Care Benefits are payable per Accident per Covered Person regardless of the number of chiropractic treatments received.

Daily Hospital Confinement Benefit: We will pay the Daily Hospital Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person was Confined in a Hospital due to an Injury received in an Accident. Confinement must begin within 90 days of the Accident and last at least 20 hours. The Daily Hospital Confinement Benefit is subject to a lifetime maximum of 365 days per Covered Person. This maximum includes all days a Covered Person is Confined in a Hospital, including days in an Intensive Care Unit of a Hospital. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Accident. The Daily Hospital Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily Hospital Confinement Benefit and the Daily Intensive Care Unit Confinement Benefit concurrently for the same Covered Person. We will also not pay this Daily Hospital Confinement Benefit and the Rehabilitation Facility Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Daily ICU Confinement Benefit: Unless the Covered Person has reached his or her lifetime maximum Daily Hospital Confinement Benefits, We will pay the Daily ICU Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in an Intensive Care Unit due to an Injury received within 30 days of an Accident. If a Covered Person is Confined in an ICU for more than 30 days, the Daily Hospital Confinement Benefit will begin on the 31st day, provided the Covered Person has not reached his or lifetime maximum for Daily Hospital Confinement benefits. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Accident. The Daily ICU Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily ICU Confinement Benefit and the Daily Hospital Confinement Benefit concurrently for the same Covered Person.

Diagnostic Exam Benefit: We will pay the Diagnostic Exam Benefit Amount shown in the Benefit Schedule if a Covered Person requires one of the following diagnostic examinations to determine the extent of an Injury sustained in an Accident:

(a) Computerized Axial Tomography (CAT);
(b) Computed Tomographies (CT Scan);
(c) Magnetic Resonance Imagings (MRIs); or
(d) Electroencephalogram (EEG).

The diagnostic exam must be scheduled within 90 days after the date of the Accident. Only 1 Diagnostic Exam Benefit Amount is payable per Accident per Covered Person regardless of the number of diagnostic examinations received.

Emergency Dental Benefit (extraction and crown): We will pay the Emergency Dental Benefit Amount shown in the Benefit Schedule if a Covered Person requires the following dental work as a result of an Injury sustained in an Accident:

(a) repair of a broken sound, natural tooth with a crown; or
(b) extraction of a broken sound, natural tooth.

The dental work must occur within 90 days after the Accident. Only one Emergency Dental Benefit Amount is payable per Accident per Covered Person regardless of the number of teeth involved.

Emergency Room Benefit: We will pay the Emergency Room Benefit Amount shown in the Benefit Schedule if a Covered Person requires examination and treatment by a Physician in an Emergency Room as the direct result of an Injury sustained in an Accident. The Emergency Room examination and treatment must occur within 72 hours after the date of the Accident. No more than 1 Emergency Room Benefits will be payable per Accident per Covered Person.

Hospital Admission Benefit: We will pay the Hospital Admission Benefit Amount shown in the Benefit Schedule if, as a result of an Injury received in an Accident, a Covered Person is admitted to a Hospital. Admission to the Hospital must occur within 90 days of the Accident. The Hospital Admission Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit.

Initial Physician's Visit Benefit: We will pay the Initial Physician's Visit Benefit Amount if a Covered Person receives initial treatment by a Physician in a Physician's office as the result of an Injury sustained in an Accident. The treatment must be given within 90 days after the Accident. Services for routine examinations or preventative testing are not included in this benefit.

Lodging Benefit: We will pay the Lodging Benefit Amount shown in the Benefit Schedule for a companion to accompany the Covered Person while the Covered Person is Confined in a Hospital due to an Injury sustained in an Accident. The Covered Person must be Confined in a Hospital located more than 100 miles from the Covered Person's residence. This benefit will be payable for one room if the companion incurs a charge for staying in a hotel or a motel while the Covered Person is Confined. This Lodging Benefit is subject to a lifetime maximum of 30 days per Covered Person.

Medical Appliance Benefit: We will pay the Medical Appliance Benefit Amount shown in the Benefit Schedule if, due to an Injury sustained in an Accident, a Covered Person requires a Medical Appliance as an aid in personal locomotion or mobility. The Medical Appliance must be prescribed by a Physician. Use of the Medical Appliance must begin within 90 days of the Accident. Only one Medical Appliance Benefit is payable per Accident per Covered Person.

Physical Therapy Benefit: We will pay the Physical Therapy Benefit Amount shown in the Benefit Schedule for each day a Covered Person requires physical therapy treatment for an Injury received in an Accident. Physical therapy must begin within 90 days of the Accident or within 90 days of the date a Physician prescribes physical therapy following surgery or other medical treatment for Injury sustained in an Accident. The Physical Therapy Benefit is subject to a maximum of 10 days per Covered Person per Accident. Physical therapy must be prescribed by a Physician and rendered by a licensed physical therapist in an office or Hospital on an Inpatient or Outpatient basis.

Rehabilitation Facility Benefit: We will pay the Rehabilitation Facility Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in a Rehabilitation Unit for physical, occupational or speech therapy treatment for an Injury received in an Accident. Confinement must begin within 90 days of the Accident and be preceded by Confinement in a Hospital. The Rehabilitation Facility Benefit is subject to a lifetime maximum of 15 days per Covered Person. We will pay benefits for only one period of Rehabilitation Facility Confinement at a time even if it is caused by more than one Accident. We will not pay this Rehabilitation Facility Benefit and the Daily Hospital Confinement Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Transportation Benefit: We will pay the Transportation Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person must travel more than 100 miles from his or her residence to a receive special treatment or be Confined in a Hospital. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to 3 round trips per Covered Person per Accident. This benefit is not payable for transportation by ambulance (air or ground).

Urgent Care Benefit: We will pay an Urgent Care Benefit if a Covered Person requires treatment or care in an Urgent Care Facility due to an Injury sustained in an Accident. The Treatment must occur within 72 hours after the date of the Accident. No more than 1 Urgent Care Benefits will be payable per Accident per Covered Person.

X-Ray Benefit: We will pay the X-Ray Benefit Amount shown in the Benefit Schedule if a Covered Person requires an x-ray as a result of an Injury sustained in an Accident. The x-ray must be prescribed by a Physician and performed in Physician's office or Hospital on an Inpatient or Outpatient basis. The x-ray must be performed within 90 days after the date of the Accident. Only one X-ray Benefit Amount is payable per Accident per Covered Person regardless of the number of x-rays received.

Dislocations Benefit (open reduction, closed reduction and incomplete): If a Covered Person sustains a Dislocation as a result of an Accident, We will pay the Dislocation Benefit Amount shown in the Benefit Schedule.

The Dislocation must be diagnosed and corrected via an open (surgical) or closed (non-surgical) reduction under anesthesia by a Physician.

If a Physician diagnoses the Dislocation as incomplete (the joint is not completely separated), or the Dislocation requires treatment without anesthesia by a Physician, We will pay 25% of the Dislocation Benefit shown in the Benefit Schedule for a closed reduction a Dislocation for that joint.

If a Covered Person sustains one or more Fractures and Dislocations due to the same Accident, We will pay both the Fractures Benefit and the Dislocations Benefit. We will pay no more than two times the amount for the bone or joint involved that has the highest benefit amount.

This benefit is payable once per joint, per Covered Person. Further Dislocations of the same joint will not be covered under the Policy after a Dislocation Benefit has already been paid for that joint.

Fractures Benefit (open reduction, closed reduction and Chip Fractures): We will pay the Fractures Benefit Amount shown in the Benefit Schedule for a Fracture sustained in an Accident. If a Covered Person sustains more than one Fracture due to the same Accident, we will pay the benefits for all Fractures to a maximum of two times the amount shown in the Benefit Schedule for the bone involved with the highest benefit amount.

If the Covered Person is diagnosed by a Physician as having a Chip Fracture, we will pay 25% of the benefit shown in the Benefit Schedule for a closed reduction of the bone.

If a Covered Person sustains a Fracture and a Dislocation due to the same Accident, we will pay both benefits. We will pay no more than two times the amount for the bone or joint involved which has the highest benefit amount.

The Fracture must be diagnosed by a Physician within 90 days of the Accident and must require open (surgical) reduction or closed (non-surgical) reduction by a Physician.

Abdominal/Thoracic Surgery Benefit: We will pay the Abdominal/Thoracic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of an Injury sustained in an Accident, a Covered Person undergoes open abdominal or thoracic surgery to repair internal Injuries. The surgery must occur within 90 days of the Accident to repair Injury. Hernia repair is not covered under this benefit. Only one Abdominal/Thoracic Surgery Benefit is payable per Accident per Covered Person. Either the Abdominal/Thoracic Surgery Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Arthroscopic Surgery Benefit: We will pay the Arthroscopic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of Accident, a Covered Person undergoes arthroscopic surgery. The surgery must occur within 90 days of the Accident to repair an Injury sustained in the Accident. Hernia repair is not covered under this benefit. Only one Arthroscopic Surgery Benefit is payable per Accident per Covered Person. We will pay either the Arthroscopic Surgery Benefit or the greater of the following benefits for the same Accident:

(a) Knee Cartilage Benefit;
(b) Ruptured Disc Benefit;

(c) Abdominal/Thoracic Surgery Benefit; or
(d) Tendon/Ligament/Rotator Cuff Benefit.

Burn Benefit: We will pay the Burn Benefit Amount shown in the Benefit Schedule if, as a result of an Injury sustained in an Accident, a Covered Person sustains either:
(a) Third Degree Burns covering at least 18 square inches of the Covered Person's body; or
(b) Second Degree Burns covering at least 34% of the Covered Person's body.
The Covered Person must be treated by a Physician within 72 hours after the date of the Accident. Only one Burn Benefit is payable per Accident per Covered Person, however if burns are in multiple degrees, then the highest benefit will be paid.

Skin Graft Benefit: We will pay the Skin Graft Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person receives a skin graft for a Third Degree Burn for which a benefit was received under the Burn Benefit. Only one Skin Graft Benefit is payable per Accident per Covered Person.

Concussion Benefit: We will pay the Concussion Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person is diagnosed with a Concussion. The Concussion must be diagnosed or treated by a Physician within 72 hours of Accident. No more than 3 Concussions will be covered per year per Covered Person.

Eye Injury Benefit: We will pay the Eye Injury Benefit Amount shown in the Benefit Schedule if a Covered Person sustains an Injury sustained in an Accident to the eye. The Injury must require surgery or removal of a foreign object by a Physician within 90 days of the Accident. Only one Eye Injury Benefit is payable per Accident per Covered Person.

Hernia Benefit: We will pay the Hernia Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a hernia. The hernia must be diagnosed by a Physician within 30 days of the Accident and must be repaired by surgery within one year from the date of the Accident.

Joint Replacement Benefit: We will pay the Joint Replacement Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains an Injury requiring a knee, hip or shoulder joint replacement. The joint replacement must be diagnosed within 90 days of the Accident and surgery must occur within one year of the Accident. Only one Joint Replacement Benefit is payable per Accident per Covered Person.

Knee Cartilage Benefit: We will pay the Knee Cartilage (with repair or without repair) Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a torn knee cartilage (meniscus). Treatment must be first provided by a Physician within 60 days of the Accident. If surgery is required, the Covered Person must undergo surgery within 12 month(s) of the Accident. Only one Knee Cartilage Benefit is payable per Accident per Covered Person. Either the Knee Cartilage Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Lacerations Benefit: We will pay the Lacerations Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a Laceration. The Laceration must be repaired by a Physician within 72 hours of the Accident. The benefit payable will be based on the total length of all Lacerations received in any one Accident which requires repair. Only one Lacerations Benefit is payable per Accident per Covered Person. If a Covered Person sustains a Laceration that later results in loss or Dismemberment, We will subtract the amount paid under the Lacerations Benefit from the Accidental Dismemberment Benefit.

Ruptured Disc Benefit: We will pay the Ruptured Disc Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person sustains a ruptured or herniated disc in the spine that must be repaired through surgery. The Covered Person must receive treatment from a Physician for the ruptured or herniated disc within 60 days of the Accident and surgery must be performed within one year of the Accident. Only one Ruptured Disc Benefit is payable per Accident per Covered Person regardless of the number of surgeries needed. Either the Ruptured Disc Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Tendon/Ligament/Rotator Cuff Benefit: We will pay the Tendon/Ligament/Rotator Cuff Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person receives a torn, ruptured or severed tendon, ligament or rotator cuff. The Injury must be treated by a Physician within 90 days of the Accident and be repaired by surgery within one year. Only one Tendon/Ligament/Rotator Cuff benefit is payable per Accident per Covered Person. Either the Tendon/Ligament/Rotator Cuff Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Coma Benefit: We will pay the Coma Benefit Amount shown in the Benefit Schedule if, as a result of an Accident, a Covered Person is diagnosed with a Coma. The Coma must be diagnosed or treated by a Physician within 90 days of the Accident. Only one Coma Benefit is payable per Accident per Covered Person.

Prosthesis Benefit: We will pay the Prosthesis Benefit Amount shown in the Benefit Schedule if, due to an Injury in an Accident, a Covered Person:

(a) loses a hand, foot, arm, leg, eye; and
(b) requires a prosthetic device, artificial limb or eye, as prescribed by a Physician.

The prosthetic device/artificial limb or eye must be received within one year after the date of the Accident. This benefit is not payable for joint replacement such as an artificial hip or knee. Only one Prosthesis Benefit is payable per Accident per Covered Person.

EXCLUSIONS

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

(a) a Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted Injury;
(b) war or act of war, whether declared or undeclared;
(c) a nuclear, chemical, biological, or radiological event;
(d) the Covered Person's participation in a felony, riot or insurrection;
(e) the Covered Person's service in the armed forces or units auxiliary to it;
(f) the Covered Person's taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
(g) a Covered Person's sickness or bacterial infection;
(h) a Covered Person's participation in bungee jumping or hang gliding;
(i) a Covered Person's participation or competition in semi-professional or professional sports;
(j) cosmetic surgery or any other elective procedure that is not medically necessary;
(k) a Covered Person being intoxicated as defined by the jurisdiction in which the cause of loss was incurred;
(l) while the Covered Person is on any aircraft:
    1) as a pilot, crewmember or student pilot;
    2) as a flight instructor or examiner;
    3) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under the Policy;
    4) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
(m) operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft. Aircraft includes those which are not motor-driven. This exclusion does not apply where the Covered Person is riding as a fare-paying passenger on a regularly scheduled commercial airline or as a passenger for transportation only and not as a pilot or crew member; or
(n) riding in or driving any motor-driven vehicle in a race, stunt show or speed test.

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 at The Hartford Supplemental Insurance Benefit Department, PO Box 99906, Grapevine, TX 76099, 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 Us written Proof of Loss at Our Home Office. 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 immediately after Our receipt of due written Proof of Loss.

Payment of Claims: Death benefits for the Primary Insured will be payable to the beneficiary that he/she designated. If no beneficiary is designated or living, the death benefit will be payable to the Primary Insured's estate. Any other accrued benefits unpaid at the Primary Insured's death may, at Our option, be paid either to the beneficiary or to the Primary Insured's estate. All other indemnities will be payable to the Primary Insured.

If any benefit is payable to the Primary Insured's estate, or to an individual who is a minor or otherwise not competent to give a valid release, We may pay such benefit, up to an amount not exceeding $1,000, to any person related to the Primary Insured by blood or marriage or the beneficiary, if We determine the person to be equitably entitled the benefit. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of the payment.

We will pay the benefits for loss of life upon the death of the any Dependents of the Primary Insured to the Primary Insured, if living. Otherwise, it will be paid, at Our option, to the Primary Insured's surviving spouse or the executor or administrator of his/her estate.

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

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:

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

Claim Appeal: On any claim, a claimant may appeal to Us for a full and fair review. To do so We:

(a) must receive a written application for review within:
    1) 180 days of receipt of claim denial if the claim requires Us to make a determination of an Injury; or
    2) 60 days of receipt of claim denial if the claim does not require Us to make a determination of an Injury; and
(b) upon request We will provide copies of all documents records, and other information relevant to the claimant's claim; and
(c) We will consider any additional written comments, documents records and other information relating to the claim.

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

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

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

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

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

PORTABILITY

Portability Benefit: Portability allows You or Your Dependent(s) to continue coverage under a group portability policy when coverage ends under this Certificate due to a Qualifying Event. If You or Your Dependent(s) qualify for and elect portability as stated in this provision, coverage will continue under a group portability policy subject to the Exclusions provision, without interruption with respect to all benefits and periods as stated in the Policy.

The terms, conditions and premium rates of the portability coverage will be governed by the portability policy. Your and Your Dependent(s) coverage under the portability policy will not continue past the Primary Insured's attainment of age 80.

If the Qualifying Event is Your death or divorce, Your Dependents coverage under the portability policy will not continue past his or her attainment of age 80.

Electing Portability: You may elect Portability if Your Accident insurance ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your coverage ends due to Your own Qualifying Event. The Policy must still be in force for Portability to be available.

Your Spouse may elect Portability for him/her and Your Dependent Child(ren) if Your coverage under the Policy ends due to Your death or divorce, if Your Spouse is under age 80 at the time of the Qualifying Event.

To elect Portability, You or Your Spouse if coverage ends due to Your death or divorce must:
(a) complete a portability application; and
(b) submit the application to Us, with the required premium.

This must be received within 31 days after accident insurance terminates. However, Portability requests will not be accepted if they are received more than 91 days after accident insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a portability policy. The Portability coverage will be:
(a) issued without evidence of insurability;
(b) issued on one of the forms then being issued by Us for Portability; and
(c) effective on the day following the date Your or Your Spouse's coverage ends, such that there is no interruption in coverage between the Policy and the portability policy.

Limitations On Portability: You may elect to continue 100% of each Covered Person's amount of insurance in force under the Policy on the date Your insurance terminates.

Your Spouse may apply for portable insurance in an amount up to 100% of the amount of Spouse Insurance and Dependent Child(ren) Insurance in force under the Policy on the date of Your death or divorce.

Your Spouse may not apply for portable insurance for a Dependent Child whose insurance has not terminated under the Policy due to divorce.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to Your own Qualifying Event.

GENERAL PROVISIONS

Entire Contract Changes: The Policy, the Application(s), this Certificate, any individual enrollment forms, riders, endorsements and any other attached papers make up the entire contract of insurance between the Policyholder and Us.

No change in the Policy or this Certificate will be valid until approved by an officer of Ours. The approval must be in writing and must be attached to or noted on the Policy. In the event of the death or incapacity of the Covered Person, no beneficiary or personal representative of the Covered Person has authority to change the Policy or this Certificate or to waive any 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 his or her beneficiary or personal representative and is attached to this Certificate.

Time Limit on Certain Defenses: After a Covered Person has been insured under the Policy for 3 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 3 year period.

Legal Actions: No legal action may start:

(a) until 60 days after Proof of Loss has been given;
(b) more than 3 years after the time Proof of Loss is required to be given.

Change of Beneficiary: The right to change of beneficiary is reserved to the Covered Person and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Policy or to any change of beneficiary or beneficiaries, or to any other changes in this Policy.

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

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:

(a) 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 Notice of Claim, 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;
(b) 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;
(c) 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;
(d) 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.

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. Merely providing false statements on Your application, without actually intending to deceive Us, does not necessarily impact future recovery nor enable Us to rescind the Certificate.

Assignment: Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign Your rights and interest under the Policy including, but not limited, to the following:

(a) the right to make any contributions required to keep the insurance in force;
(b) the right to convert; and
(c) the right to name and change a beneficiary.

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

(a) it is duly executed; and
(b) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

(a) for the validity or effect of any assignment; or
(b) to provide any assignee with notices which We may be obligated to provide to You.

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

Unpaid Premium: Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, conflicts with the statute of the state in which You reside on such date is hereby amended to meet the minimum requirements of such statutes.

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.

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

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

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

COVERAGE

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

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

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

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

  - Life Insurance
    80% of death benefits but not to exceed $300,000
    80% of cash surrender or withdrawal values but not to exceed $100,000

  - Annuities and Structured Settlement Annuities
    80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

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

- **Health Insurance**

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

(please turn to next page)

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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

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 NIAGARA BOTTLING LLC:

   Group Accident Plan

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2. **Plan Number**

   Group Accident - 503

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3. **Employer/Plan Sponsor**

   NIAGARA BOTTLING LLC
   1440 BRIDGEGATE DR
   DIAMOND BAR, CA 91765

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4. **Employer Identification Number**

   33-0843510

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Accident Coverage

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6. **Plan Administrator**

   NIAGARA BOTTLING LLC
   1440 BRIDGEGATE DR
   DIAMOND BAR, CA 91765

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

   For the Plan

   NIAGARA BOTTLING LLC

1440 BRIDGEGATE DR
DIAMOND BAR, CA 91765

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

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

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

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

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

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

Claims for Benefits

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

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

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

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

similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

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

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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