Group Accident Plan

Prepared Exclusively For
NIAGARA BOTTLING LLC

Off Job Accident Plan

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Certificate

This Certificate is part of the Group Accident Policy between Aetna Life Insurance Company and the Policyholder

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AETNA LIFE INSURANCE COMPANY

ACCIDENT ONLY

OUTLINE OF COVERAGE

Read Your Certificate Carefully. This outline of coverage provides a very brief description of some important features of your certificate. This is not the insurance contract and only the actual certificate provisions will control. The certificate itself sets forth, in detail, the rights and obligations of both you and Aetna. It is, therefore, important that you Read Your Certificate Carefully!

Accident Only Coverage. This category of coverage is designed to provide, to persons insured, benefits for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the certificate. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Some notes on how we use words:

- Some words appear in **bold** type. **We** define them in the Glossary section of **your** certificate.
- When we say "**we,**" we mean **Aetna.**
- When we say "**you**" and "**your,**" **we** mean the **employee.**

Benefits. Refer to the Schedule of Benefits and Benefits sections of the certificate and the Rider Schedule and Rider Benefit sections of the Health Screening Benefit Certificate Rider and Inpatient Hospital Benefit due to Sickness Certificate Rider for details about when benefits are payable and what your benefits are.

Exceptions and Limitations. Refer to the Exclusions section of the certificate and the Rider Exclusions and Limitations section of the Inpatient Hospital Benefit due to Sickness Certificate Rider for details about when benefits are not payable and what limitations apply to your plan.

Eligibility, Termination and Portability. Refer to the Eligibility, Termination of Coverage and Portability Provision sections of the certificate for information about eligibility for coverage, termination of coverage and portability.

Premium or Contribution. The cost of the coverage is included within the premium or contribution paid by **you** and/or **your employer** for the plan.

Group Accident Certificate

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

The words which appear in **bold** type are defined in the Definitions section of this Certificate.

This Certificate explains the insurance benefits issued to the **policyholder** named in the Schedule of Benefits. **We** agree to pay the benefits to each **insured person** in accordance with the terms of the Policy.

The Policy under which this Certificate is issued may be amended or cancelled at any time as stated in its provisions. Only an officer of Aetna Life Insurance Company may approve a change and it must be done in writing. Such action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

THIS CERTIFICATE IS NOT MEDICARE SUPPLEMENT COVERAGE. IF **YOU** ARE ELIGIBLE FOR MEDICARE, REVIEW "THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE", WHICH IS AVAILABLE FROM **US**.

This Certificate replaces any previous certificate(s) issued to the **employee** under the Policy.

Signed for Aetna Life Insurance Company.
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President

The Policy is a non-participating Policy and does not share in the company's surplus.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This plan provides limited benefits. The benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

This plan does not count as minimum essential coverage under the Affordable Care Act.

PLEASE READ THIS CERTIFICATE CAREFULLY.

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Eligibility

An employee of the **employer** is in an eligible class if he or she is a regular, **actively-at-work** employee of the **employer**, according to criteria the **employer** sets to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to his or her employment. **We** will rely upon the representation of the **employer** as to eligibility for coverage under this plan and as to any fact concerning such eligibility. Eligibility for insurance may be modified to accommodate the **employer's** common practices.

To be covered by this plan, the following requirements must be met:

- The eligible employee will need to be in an eligible class, as defined by the **employer**;
- The eligible employee has reached his or her eligibility date; and
- The eligible employee has completed the **employer's** eligibility waiting period or probationary period.

Dependents

Your dependents can be covered under **your** plan. **You** may enroll the following dependents:

- **Your** legal spouse or **civil union** partner.
- **Your** domestic partner who meets the requirements of the California Family Code Section 297.
- **Your** dependent children.

We will rely upon **your employer** to determine whether or not a person meets the definition of a dependent for coverage under this plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

To be eligible, a dependent child must be:

- Under 26 years of age; or
- Over the limiting age shown above who is not able to earn his or her own living because of mental or physical handicap which started prior to the date he or she reaches the limiting ages and who is chiefly dependent on **you** for support and maintenance. **We** require proof of such incapacity no later than 31 days after the date the child's coverage would otherwise have terminated due to the limiting age. **We** have the right to require proof of the continuation of the incapacity, at **our** expense, as often as needed, but not more often than once each two years from the date the child reached the limiting age.

An eligible dependent child includes:

- **Your** biological children;
- **Your** stepchildren;
- **Your** legally adopted children and children placed with you for adoption;
- **Your** domestic partner's children;
- **Your civil union** partner's children;
- **Your** children for whom you are required to provide coverage under a medical support order; and
- Any other child who lives with **you** in a parent-child relationship.

Important Reminder
Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Enrollment Procedure

An eligible employee will be provided with plan benefit and enrollment information when he or she first becomes eligible to enroll. To complete the enrollment process, all requested information for the eligible employee and his or her eligible dependents must be provided. Eligible employees will also need to agree to make required premium payments. The **employer** will determine the amount of required premium contribution, which will need to be agreed to before enrollment. The **employer** will advise of the required amount of premium contribution. Premiums are subject to change.

Enrollment will need to be made within 31 days of the eligibility date. If an eligible employee misses the enrollment period, he or she will not be able to participate in this plan until the next annual enrollment period. If an eligible employee does not enroll for coverage when he or she first becomes eligible, but wishes to do so later, the **employer** will provide the information on when and how enrollment can be done. Newborns are automatically covered for 31 days from the moment of live birth provided payment of premium is received by **us**. To continue coverage after 31 days, **you** will need to complete an Enrollment/Change Request form and return it to **your employer** within the 31-day enrollment period.

Effective Date of Coverage

If an eligible employee has met all the eligibility requirements, his or her coverage takes effect on the later of:

- The date his or her required premium payment is received by **us**; or
- Such other date as set forth in criteria established between the **employer** and **us**.

Important Note:

Actively-at-work rule:
If an eligible employee is not **actively-at-work** due to **sickness, accidental injury** or leave of absence, the coverage will not take effect until after he or she has returned to work and have completed one regularly scheduled work day; week.

This means that he or she must be **available to work** on the effective date of coverage in order to be eligible for coverage under this plan. He or she will be considered **available to work if** he or she meets the eligibility requirements, if any, specified by the **employer** to govern eligibility for coverage under this plan, or if he or she has accrued hourly fringe benefit contributions.

This rule also applies to an increase in **your** coverage.

Your dependent's coverage takes effect on the same day that **your** coverage becomes effective, if **you** have enrolled them in this plan by then.

Note: New dependents need to be reported to **us** within 31 days because they may affect **your** premium payment. If **you** do not report a new dependent within 31 days of his or her eligibility date, then that dependent will not be able to participate in the plan until **your employer's** next annual enrollment period.

Adopted Children and Medical Support Orders:

1. An adopted child who meets the definition of dependent as of the moment the child is placed in **your** physical custody for adoption, may be enrolled provided:

   - Such placement takes effect after the date **your** coverage becomes effective; and
   - **You** make written request for coverage for the child within 31 days of the date the child is placed with **you** for adoption because they may affect **your** premium payment. If **you** do not report the child within 31 days of his or her eligibility date, that child will not be able to participate in this plan until **your employer's** next annual enrollment period, if any.

   As used here, "placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

2. A child for whom **you** are required to provide health coverage as the result of a qualified medical child support order and who meets the definition of dependent, may be enrolled provided:

   - The support order was issued on or after the date **your** coverage becomes effective; and
   - **You** make written request for coverage for the child within 31 days of the date of the support order because they may affect **your** premium payment. If **you** do not report the child within 31 days of his or her eligibility date, that child will not be able to participate in this plan until **your employer's** next annual enrollment period, if any.

   If **you** are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Coverage for the child will become effective on the date specified by **your employer**.

Premium Provisions

We require that **you** make premium contributions.

If payments are made through a payroll deduction with **your employer**, **your employer** will forward **your** payment to **us**.

Our Right to Change Premium Rates. We have the right to change **our** premium rates. **We** will give the **policyholder** at least 31 days prior written notice of any change.

Refund of Unearned Premium. If coverage under this Certificate for an **insured person** terminates for any reason, **we** will promptly refund any unearned premium with respect to such **insured person**.

Schedule of Benefits

Policyholder:	**NIAGARA BOTTLING LLC**
Group Policy No.:	GP-802363
Issue Date:	December 18, 2017
Group Policy Effective Date:	March 1, 2018
Plan Year:	March 1st to February 28th

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Accidental Follow-up Benefit	$50
Maximum Visits per **Accident**	2
Maximum Visits per **Plan Year**	6
Ground Ambulance Benefit	$300
Maximum Trips per **Accident**	1
Air Ambulance Benefit	$1,500
Maximum Trips per **Accident**	1
Appliances Benefit	$50
Maximum Appliances per **Accident**	1
Blood/Plasma/Platelets Benefit	$300
Maximum Transfusions per **Accident**	1
Burn Benefit	
Burn Classifications:	
Second Degree Burn, greater than 5% of total body surface	$500
Third Degree Burn, less than 5% of total body surface	$750
Third Degree Burn, 5-10% of total body surface	$3,000
Third Degree Burn, greater than 10% of total body surface	$9,000
Burn Skin Graft Benefit	50% of Burn Benefit
Maximum Skin Grafts per **Accident**	1
Chiropractic Treatment Benefit	$15
Maximum Visits per **Accident**	10
Maximum Visits per **Plan Year**	30
Coma Benefit	$5,000
Maximum Coma per **Accident**	1
Concussion Benefit	$100
Maximum Concussion per **Accident**	1
Dental Treatment Benefit	
Extractions	$50
Crown	$150

Dislocation Benefit	
Closed Reduction	
Hip	$2,000
Knee (except Patella)	$1,000
Ankle - Bone or Bones of the foot (other than toes)	$500
Collarbone (Sternoclavicular)	$400
Lower Jaw (or associated bone joints)	$400
Shoulder (Glenohumera)	$400
Elbow	$400
Wrist	$400
Bone or Bones of the hand (other than fingers)	$400
Collarbone (Acromiociociavicular and separation)	$100
One toe or one finger	$100
Open Reduction	1.5 x Closed Reduction
Maximum Dislocations per **Accident**	1

Eye Injury Benefit	$200
Maximum Visits per **Accident**	1

Fracture Benefit	
Closed Reduction	
Skull (except bones of the face or nose), depressed	$2,750
Skull (except bones of the face or nose), non-depressed	$2,750
Hip, Thigh (Femur)	$1,150
Vertebrae, Body of (excluding Vertebral Processes)	$750
Pelvis (inc. Ilium, Ishicum, Pubis, Acetabulum except Coccyx)	$750
Leg (Tibia and/or Fibula Malleolus)	$750
Bones of the Face or Nose (except Mandible or Maxilla)	$400
Upper Jaw (or associated bone joints), Maxilla (except Alveolar Process)	$400
Upper Arm between Elbow and Shoulder (Humerous)	$400
Lower Jaw (or associated bone joints), Maxilla (except Alveolar Process)	$400
Collarbone, (Clavicle, Sternum)	$400
Shoulder Blade (Scapula)	$400
Vertebral Process	$400
Forearm (Radius and/or Ulna)	$300
Kneecap (Patella)	$300
Hand/Foot (except fingers and toes)	$300
Ankle/Wrist	$300
Rib	$150
Coccyx	$150
Finger, Toe	$150
Open Reduction	1.5x Closed Reduction
Maximum Fractures per **Accident**	1

Hospital Stay - Admission Benefit	
Hospital Admission	$1,000
Maximum Admissions per **Accident**	1
Hospital Stay - Daily Benefit	
Hospital Daily	$100
Maximum Days per **Stay**	365
Maximum **Stays** per **Accident**	1
Rehabilitation Unit Daily	$100
Maximum Days per **Stay**	30
Maximum **Stays** per **Accident**	1
Initial Treatment Benefit - Emergency Room	$100
Maximum Visits per **Accident**	1
Maximum Visits per **Plan Year**	3
Initial Treatment Benefit - Physician's Office or Urgent Care Center	$100
Maximum Visits per **Accident**	1
Maximum Visits per **Plan Year**	3
Laceration Benefit	
Repair Classifications:	
Without stitches	$25
With stitches, less than 7.5 centimeters	$75
With stitches, 7.6 - 20.0 centimeters	$300
With stitches, greater than 20.0 centimeters	$600
Maximum Repairs per **Accident**	1
Lodging Benefit	$100
Maximum Days per **Accident**	30
Medical Imaging Benefit	$100
Maximum Imaging Tests per **Accident**	1
Observation Unit Benefit	$100
Maximum Observations per **Accident**	1
Pain Management (Epidural Anesthesia) Benefit	$50
Maximum Administrations per **Accident**	1
Prosthetic Device/Artificial Limb Benefit	
One Limb	$500
Multiple Limbs	$1,000
Ruptured Disc Benefit	$500
Maximum Repairs per **Accident**	1

Surgery Benefit (with repair)	
Cranial, Open Abdominal & Thoracic	$500
Hernia	$100
Maximum Surgeries (with repair) per **Accident**	1
Surgery Benefit (with no repair)	
Exploratory or Arthroscopic	$100
Maximum Surgeries (with no repair) per **Accident**	1
Tendon/Ligament/Rotator Cuff Benefit	
Surgery for Single Repair	$500
Surgery for Multiple Repairs	$1,000
Maximum Surgeries per **Accident**	1
Therapy Services Benefit - Speech Therapy, Occupational Therapy and Physical Therapy)	$15
Maximum Visits per **Accident**	10
Torn Knee Cartilage Benefit	$500
Maximum Repairs per **Accident**	1
Transportation Benefit	$200
Maximum Round Trips per **Accident**	1
X-ray Benefit	$25
Maximum X-rays per **Accident**	1

Benefits

If an **insured person** has an **accidental injury**, **we** will pay the applicable benefits shown on the Schedule of Benefits for the below listed benefits subject to the following:

1. The benefit maximums, if any, shown on the Schedule of Benefits;
2. A charge must be incurred for the **care** of an **insured person** due to an **accidental injury**;
3. The service or supply must be rendered or received due to an **accidental injury** and is not due to or in connection with an **occupational injury**;
4. The **accidental injury** must occur while coverage for the **insured person** is in force;
5. The service or supply must be rendered or received while coverage for the **insured person** is in force;
6. The service or supply must be rendered or received in the United States or its territories; and
7. The **accident** must take place in the United States or its territories.

We reserve the right to request that a **physician** of **our** choice review any **diagnosis** in the event of a dispute or disagreement regarding the appropriateness or correctness of a **diagnosis**. **We** also reserve the right to require that an **insured person** submit to an examination to confirm a disputed **accidental injury**. **We** reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed **diagnosis**. **We** will pay for any such requested examination or review.

Accident Follow-up Benefit

We will pay the Accident Follow-up Benefit shown on the Schedule of Benefits if an **insured person** receives follow-up treatment in a **physician's** office, **urgent care center** or **emergency room** for an **accidental injury** within one year of the **accident**.

We will pay either, the Accident Follow-up Benefit, the Initial Treatment Benefit **–** Emergency Room or the Initial Treatment Benefit – Physician's Office or Urgent Care Center if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

We will pay either, the Accident Follow-up Benefit or the Therapy Services Benefit if those visits occur on the same day for the same **accidental injury**. When the visits occur on the same date, the benefit with the greatest amount is payable.

Ground Ambulance Benefit

We will pay the Ground Ambulance Benefit shown on the Schedule of Benefits if a licensed professional ambulance company transports any **insured person** by ground to or from a **hospital** or between medical facilities where treatment is received as the result of an **accidental injury**.

The ground ambulance transportation must take place within 24 hours after **accidental injury**.

We will pay either, the Ground Ambulance Benefit or the Air Ambulance Benefit if both ground and air transportation takes place on the same date for the same **accidental injury**. When both transports take place on the same date, the benefit with the greatest amount is payable.

Air Ambulance Benefit

We will pay the Air Ambulance Benefit shown on the Schedule of Benefits if a licensed professional air ambulance company transports any **insured person** by air to or from a **hospital** or between medical facilities where treatment is received as the result of an **accidental injury**.

The air ambulance transportation must take place within 48 hours after the **accidental injury**.

We will pay either, the Air Ambulance Benefit or the Ground Ambulance Benefit if both ground and air transportation takes place on the same date for the same **accidental injury**. When both transports take place on the same date, the benefit with the greatest amount is payable.

Appliances Benefit

We will pay the Appliances Benefit shown on the Schedule of Benefits if a **physician** prescribes the use of an **appliance** as an aid in personal locomotion or mobility as a result of an **accidental injury**.

The use of an **appliance** must begin within 90 days after of the **accidental injury**.

Blood/Plasma/Platelets Benefit

We will pay the Blood/Plasma/Platelets Benefit shown on the Schedule of Benefits if an **insured person** receives the transfusion of blood, plasma and/or platelets due to an **accidental injury**.

The transfusion must take place within 90 days after the **accidental injury**.

Burn Benefit

We will pay the applicable Burn Benefit shown on the Schedule of Benefits if an **insured person** receives a **second degree burn** or **third degree burn** as a result of an **accidental injury**.

Treatment must be received by a **physician** within 72 hours after the **accidental injury**.

The Burn Benefit is payable for one of the burn classification amounts shown on the Schedule of Benefits per **accident**. If the **insured person** sustains more than one burn classification, the benefit payable is the greater amount.

Burn Skin Graft Benefit

We will pay the Burn Skin Graft Benefit shown on the Schedule of Benefits if an **insured person** receives a skin graft for a burn as a result of an **accidental injury**.

Treatment must be received by a **physician** within 72 hours after the **accidental injury**.

Chiropractic Treatment Benefit

We will pay the Chiropractic Treatment Benefit shown on the Schedule of Benefits if an **insured person** suffers a structural imbalance due to an **accidental injury** and receives **chiropractic care services** by a chiropractor in a chiropractor's office.

Treatment must begin within 90 days after the **accidental injury** and must be completed within 365 days after the **accidental injury**.

Coma Benefit

We will pay the Coma Benefit shown on the Schedule of Benefits if an **insured person** is in a **coma** as a result of an **accidental injury**. Benefits will not be paid for a medically induced **coma**.

If **we** pay the Coma Benefit then the **insured person** dies as a result of the same **accidental injury**, the Accidental Death Benefit payable or the Accidental Death Common Carrier Benefit payable, whichever applies, will be reduced by the amount paid under this Coma Benefit.

Concussion Benefit

We will pay the Concussion Benefit shown on the Schedule of Benefits if an **insured person** sustains a concussion as the result of an **accidental injury**.

A **physician** must **diagnose** the concussion within 72 hours after the **accidental injury**.

Dental Treatment Benefit

We will pay the applicable Dental Treatment Benefit shown on the Schedule of Benefits if an **insured person** sustains a broken tooth as the result of an **accidental injury** and the tooth is repaired by a dental crown and/or dental extraction.

The dental services must begin within 60 days after the **accidental injury**.

Regardless of the number of broken teeth, only one dental crown benefit and one dental extraction benefit will be paid per **accident**.

Dislocation Benefit

We will pay the applicable Dislocation Benefit shown in the Schedule of Benefits if an **insured person** sustains a **dislocation** as the result of an **accidental injury**.

A **physician** must **diagnose** the **dislocation** within 90 days after the **accidental injury** and correct it by **open reduction** or **closed reduction**.

We will pay the applicable Dislocation Benefit only for the first **dislocation** of a joint after the **insured person's** effective date of coverage. This benefit will not be paid for subsequent **dislocations** of the same joint after the effective date of coverage.

We will pay either the applicable Dislocation Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

If the **insured person**:

1. Sustains more than one joint **dislocation**, **we** will pay for each **dislocation**, but no more than two times the applicable Dislocation Benefit for the joint involved which has the greatest benefit amount.
2. Receives reduction by a **physician** without anesthesia, **we** will pay 25% of the applicable Dislocation Benefit shown in the Schedule of Benefits for a Closed Reduction of the joint involved.
3. Is **diagnosed** by a **physician** with an incomplete dislocation, **we** will pay 25% of the applicable Dislocation Benefit shown in the Schedule of Benefits for a Closed Reduction of the joint involved. An incomplete dislocation is a dislocation in which the joint is not completely separated.
4. Sustains a **dislocation** and a **fracture** as a result of the same **accident**, both benefits are payable. However, **we** will pay no more than two times the amount for the joint or bone involved which has the greatest amount.

Eye Injury Benefit

We will pay the Eye Injury Benefit shown on the Schedule of Benefits if an **insured person** sustains an **accidental injury** to the eye.

The eye injury must require surgery or the removal of a foreign object by a **physician** within 90 days after the **accidental injury**. An examination with anesthesia will not be considered surgery.

Fracture Benefit

We will pay the applicable Fracture Benefit shown in the Schedule of Benefits if an **insured person** sustains a **fracture** as the result of an **accidental injury**.

A **physician** must **diagnose** the **fracture** within 90 days after the **accidental injury** and correct it by **open reduction** or **closed reduction**.

We will pay this benefit only for the first **fracture** of any bone after the **insured person's** effective date of coverage. If there are multiple **fractures** to the same bone, **we** will pay only one Fracture Benefit.

We will pay either the applicable Fracture Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

If the **insured person**:

1. Sustains a **fracture** of more than one bone, **we** will pay for each **fracture**, but no more than two times the applicable Fracture Benefit for the bone involved which has the highest benefit amount.
2. Is **diagnosed** by a **physician** with a chip fracture, **we** will pay 25% of the applicable Fracture Benefit shown in the Schedule of Benefits for the Closed Reduction for the bone involved. A chip fracture is a **fracture** in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.
3. Sustains a **fracture** and a **dislocation** as a result of the same **accident**, both benefits are payable. However, **we** will pay no more than two times the amount for the bone or joint involved which has the greatest amount.

Hospital Stay - Admission Benefit

Hospital Admission:
We will pay the Hospital Admission Benefit shown on the Schedule of Benefits if an **insured person** has a **stay** in a **hospital** due to an **accidental injury**.

The **stay** must begin within 180 days after an **accidental injury**.

We will only pay either the Hospital Admission Benefit or the ICU Admission Benefit once per **accidental injury**. If admitted directly:

- Into the **hospital**, then the Hospital Admission Benefit is payable.
- Into the **ICU**, then the ICU Admission Benefit is payable.

Hospital Stay - Daily Benefit

Hospital Daily:

- **We** will pay the Hospital Daily Benefit shown on the Schedule of Benefits if an **insured person** has a **stay** in a **hospital** due to **accidental injury**.

- The **stay** must begin within 180 days after an **accidental injury**.

Rehabilitation Unit Daily:
We will pay the Rehabilitation Unit Daily Benefit shown in the Schedule of Benefits if an **insured person** is transferred to a **rehabilitation unit** immediately after a **stay** in a **hospital** due to an **accidental injury**.

We will pay either the Hospital Daily Benefit or the ICU Daily Benefit if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

We will pay either the Hospital Daily Benefit or the Rehabilitation Unit Daily Benefit if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Initial Treatment Benefit – Emergency Room

We will pay the Initial Treatment Benefit **–** Emergency Room shown on the Schedule of Benefits if an **insured person** requires initial examination and treatment in an **emergency room** as the result of an **accidental injury**.

Such initial examination and treatment must be received within 72 hours after the **accidental injury**.

We will pay either the Initial Treatment Benefit - Emergency Room or the Initial Treatment Benefit **-** Physician's Office or Urgent Care Center for the same **accidental injury**, whichever occurs first.

If follow-up treatment is prescribed by a **physician**, the Accident Follow-up Benefit is payable if the follow-up visit for the same **accidental injury** occurs on a different date as the initial examination and treatment in an **emergency room**.

Initial Treatment Benefit - Physician's Office or Urgent Care Center

We will pay the Initial Treatment Benefit - Physician's Office or Urgent Care Center on the Schedule of Benefits if an **insured person** requires initial examination and treatment in a **physician's** office or **urgent care center** as the result of an **accidental injury**.

Such initial examination and treatment must be received within 72 hours after the **accidental injury**.

We will pay either the Initial Treatment Benefit **-** Physician's Office or Urgent Care Center or the Initial Treatment Benefit - Emergency Room for the same **accidental injury**, whichever occurs first.

If follow-up treatment is prescribed by a **physician**, the Accident Follow-up Benefit is payable if the follow-up visit for the same **accidental injury** occurs on a different date as the initial examination and treatment in a **physician's** office or **urgent care center**.

Laceration Benefit

We will pay the applicable Laceration Benefit shown on the Schedule of Benefits if an **insured person** receives a **laceration** as the result of an **accidental injury**.

The **laceration** must be repaired by a **physician** within 72 hours after the **accidental injury**.

If the **laceration** is severe enough to require stitches but the **physician** chooses to repair it in another way, **we** will pay the benefit amount that corresponds to "with stiches".

The Laceration Benefit is payable for one of the repair classification amounts shown on the Schedule of Benefits per **accident**. If the **insured person** sustains more than one repair classification, the benefit payable is the greater amount.

If the Laceration Benefit is paid then the **insured person** who received a **laceration** on a hand, foot or eye and later loses that hand, foot or eye as the result of the same **accidental injury**, the applicable Accidental Dismemberment Benefit payable will be reduced by the amount paid under this Laceration Benefit.

Lodging

We will pay the Lodging Benefit shown on the Schedule of Benefits for one motel/hotel room for a companion to accompany an **insured person** who has a **hospital stay** as the result of an **accidental injury**.

This benefit is payable only for motel/hotel stays during the period of time the **insured person** has a **hospital stay**. In order for this benefit to be payable, the **hospital** must be more than 50 miles from the residence of the **insured person**. **We** will measure the mileage for the most direct route from the **insured person's** residence to the motel/hotel.

Medical Imaging Benefit

We will pay the Medical Imaging Benefit shown on the Schedule of Benefits if an **insured person** receives a medical imaging test due to an **accidental injury**. Medical imaging tests include only the following:

- Positron Emission Tomography (PET)
- Computed Tomography Scan (CT)
- Computed Axial Tomography (CAT)
- Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI)
- Electroencephalogram (EEG)

The test must be ordered by a **physician** and performed in a medical facility on an inpatient or outpatient basis within 180 days after the **accidental injury**.

Observation Unit Benefit

We will pay the Observation Unit Benefit shown on the Schedule of Benefits if an **insured person** requires services in an **observation unit** as the result of an **accidental injury**. The Hospital Stay Admission Benefit will not be payable if the Observation Unit Benefit is payable.

Observation services must begin within 72 hours after the **accidental injury**.

We will pay the Observation Unit Benefit, or the Initial Treatment Benefit – Emergency Room, or the Initial Treatment Benefit – Physician's Office or Urgent Care Center for the initial treatment of an **accidental injury**, whichever occurs first.

Pain Management (Epidural Anesthesia) Benefit

We will pay the Pain Management Benefit shown on the Schedule of Benefits if an **insured person** receives **epidural anesthesia** as the result of an **accidental injury**.

The **epidural anesthesia** must be administered within 60 days after the **accidental injury**.

Prosthetic Device/Artificial Limb Benefit

We will pay the Prosthetic Device/Artificial Limb Benefit shown on the Schedule of Benefits if an **insured person** receives one or more prosthetic device(s)/artificial limb(s) when the **insured person** loses a hand, foot or one eye as the result of an **accidental injury**.

The prosthetic device(s)/artificial limb(s) must be received within one year of the **accidental injury**.

We will not pay a benefit for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs, or for joint replacement such as artificial hip or knee.

Ruptured Disc Benefit

We will pay the Ruptured Disc Benefit shown on the Schedule of Benefits if an **insured person** sustains a ruptured disc in the spine as the result of an **accidental injury**.

A **physician** must**:**

- Treat the ruptured disc within 60 days after the **accidental injury**; and
- Repair it through surgery within one year after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, **we** will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per **accidental injury**.

We will pay either the Ruptured Disc Benefit or the Surgery Benefit (with no repair) for the same **accidental injury** if treatment occurs on the same date. When treatment occurs on the same date, **we** will pay the benefit with the highest benefit amount.

Surgery Benefit (with repair)

Cranial, Open Abdominal & Thoracic:

- **We** will pay the Surgery Benefit for Cranial, Open Abdominal & Thoracic shown on the Schedule of Benefits if an **insured person** undergoes cranial, open abdominal or thoracic surgery, and repair is done, within 72 hours of the **accidental injury**.

Hernia:

- **We** will pay the Surgery Benefit for Hernia shown on the Schedule of Benefits if an **insured person** undergoes hernia surgery as the result of an **accidental injury**.

A physician must:

- **Diagnose** the hernia within 30 days after the **accidental injury**; and
- Perform surgery within 60 days after the **accidental injury**.

If an **insured person** has open abdominal and hernia surgery, or thoracic and hernia surgery, on the same date for the same **accidental injury**, only the Surgery Benefit for Cranial, Open Abdominal & Thoracic is payable.

We will pay either the Surgery Benefit (with repair) or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Surgery Benefit (with no repair)

We will pay the Surgery Benefit (with no repair) shown on the Schedule of Benefits if an **insured person** undergoes exploratory or arthroscopic surgery, and no repair is done, within 60 days of the **accidental injury**.

We will pay either the Surgery Benefit (with no repair) or the Surgery Benefit (with repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

We will pay either the Surgery Benefit (with no repair) or one of the following benefits if treatment occurs on the same date for the same **accidental injury**:

- Dislocation Benefit;
- Fracture Benefit;
- Ruptured Disc Benefit;
- Surgery Benefit (with repair);
- Tendon/Ligament/Rotator Cuff Benefit; or
- Torn Knee Cartilage Benefit.

When treatment occurs on the same date, the benefit with the greatest amount is payable.

Tendon/Ligament/Rotator Cuff Benefit

We will pay the applicable Tendon/Ligament/Rotator Cuff Benefit shown on the Schedule of Benefits if an **insured person** sustains a torn, ruptured or severed tendon, ligament or rotator cuff as the result of an **accidental injury**.

We will pay the Surgery for Single Repair Benefit or the Surgery for Multiple Repairs Benefit if a **physician**:

- Treats the tear, rupture or sever within 60 days after the **accidental injury**; and
- Repairs it through surgery within 180 days after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, **we** will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per **accidental injury**.

We will pay either the Tendon/Ligament/Rotator Cuff Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Therapy Services Benefit – Speech Therapy, Occupational Therapy and Physical Therapy

We will pay the Therapy Services Benefit shown on the Schedule of Benefits if an **insured person** receives **speech therapy**, **occupational therapy** or **physical therapy** as the result of an **accidental injury**. The therapy must be:

- prescribed by a **physician**;
- rendered by an **speech therapist**, **occupational therapist** or **physical therapist**; and
- performed in an office or in a **hospital** on an inpatient or outpatient basis.

The therapy must begin within 90 days after the **accidental injury** and must be completed within one year after the **accidental injury**.

We will pay either the Therapy Services Benefit or the Accident Follow-up Benefit if those visits occur on the same day for the same **accidental injury**. When the visits occur on the same date, the benefit with the greatest amount is payable.

Torn Knee Cartilage Benefit

We will pay the Torn Knee Cartilage Benefit shown on the Schedule of Benefits if an **insured person** sustains a torn knee cartilage (meniscus) as the result of an **accidental injury**.

A **physician** must:

- Treat the torn knee cartilage within 60 days after the **accidental injury**; and
- Repair it through surgery within 180 days after the **accidental injury**.

If exploratory or arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), **we** will pay the Surgery Benefit (with no repair) shown in the Schedule of Benefits once per **accidental injury**.

We will pay either the Torn Knee Cartilage Benefit or the Surgery Benefit (with no repair) if treatment occurs on the same date for the same **accidental injury**. When treatment occurs on the same date, the benefit with the greatest amount is payable.

Transportation Benefit

We will pay the Transportation Benefit shown in the Schedule of Benefits for an **insured person** who must travel from his or her residence more than 50 miles one way on **physician's** advice for treatment as the result of an **accidental injury**.

The Transportation Benefit will be paid for:

- A **hospital stay**;
- Outpatient surgery; or
- A **physician's** office visit.

We will pay this benefit when the injured **insured person** travels to and from the **insured person's** destination via:

- Commercial travel (plane, train or bus); or
- Non-commercial travel (use of a personal car).

We will measure the mileage for the most direct route from the **insured person's** residence to the facility where treatment is received.

This benefit is not payable if the **insured person** is transported by taxi, ground ambulance or air ambulance.

X-ray Benefit

We will pay the X-Ray Benefit shown on the Schedule of Benefits if an **insured person** receives an X-ray due to an **accidental injury**.

The X-ray(s) must be prescribed by a **physician** and performed by a licensed facility within 30 days after the **accidental injury**.

Exclusions

Benefits under the Policy will not be payable for any loss or **accidental injury** caused in whole or in part by or resulting in whole or part from the following:

- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a **diagnosed** disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
- Engaging in felony crimes;
- Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection;
- Operating, learning to operate or serving as a crewmember of an aircraft, whether motorized or not;
- Engaging in hang gliding, bungee jumping, parachuting, sail gliding, parasailing, mountaineering using ropes and/or other equipment, or motor-driven vehicle racing;
- Participating in any semi-professional or professional competitive athletic contest, including officiating or coaching, for which the **insured person** receives any compensation or remuneration;
- Services ordered or performed by a **physician**, or supplies purchased from a provider, who is an **insured person**, the **insured person's immediate family member**, or someone who resides with or is employed by or who employs an **insured person**;
- Any form of intentional asphyxiation;
- Elective or cosmetic surgery;
- Bacterial infection that was not caused by a cut or wound from an **accidental injury**.
- **Occupational injuries**.

We will not pay any benefits for a service or supply rendered or received that are not specifically covered or not related to an **accidental injury**.

General Provisions

Independent, Non-Coordinated Benefits. Each benefit under the Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under the Policy is payable with respect to any event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under the Policy will not be reduced on account of any other health insurance coverage or health plan.

Complaints. If the **insured person** is dissatisfied with the service received from this plan, the **insured person** must call or write Member Services within 30 calendar days of the incident. The complaint must include a detailed description of the matter and include copies of any records or documents that are relevant to the matter. **We** will review the information and provide a written response to the **insured person** within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will explain what the **insured person** needs to do to seek an additional review.

Assignments of Your Coverage. Coverage may not be assigned. An assignment is the transfer of **your** rights under this Certificate to a person **you** name.

Overpayments. We have the right to recover any overpayments due to fraud and any error **we** make in processing a claim. **You** must reimburse **us** in full. **We** will determine the method by which the repayment is to be made.

Unpaid Premium. Any unpaid premium due for an **insured person's** coverage under the Policy may be recovered by **us** by offsetting against amounts otherwise payable under the Policy.

Notice of Claim. Written notice of claim must be given to **us** within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **covered person** or the beneficiary to the **covered person** at Aetna Voluntary, P.O. Box 14079, Lexington, KY 40512-4079, or to any of **our** authorized agents, with information sufficient to identify the **covered person**, shall be deemed notice to **us**.

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

Proof of Loss. Written proof of loss must be furnished to **us** at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of loss includes a completed and signed claim form and any supporting documentation from the **insured person's physician**.

Time of Payment of Claims. Indemnities payable under the Policy for any loss will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss.

Payment of Claims. Accrued indemnities unpaid at the **covered person's** death may, at **our** option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the **covered person**.

If any indemnity of the Policy shall be payable to the estate of the **covered person**, or to a **covered person** or beneficiary who is a minor or otherwise not competent to give a valid release, **we** may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the **covered person** or beneficiary who is deemed by **us** to be equitably entitled thereto. Any payment made by **us** in good faith pursuant to this provision shall fully discharge **us** to the extent of such payment.

Physical Examination and Autopsy. **We** at **our** own expense shall have the right and opportunity to examine the person of the **covered person** when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions. No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Change of Beneficiary. Unless the **covered person** makes an irrevocable designation 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 the Policy or to any change of beneficiary or beneficiaries, or to any other changes in the Policy.

Workers' Compensation. The Policy is not a Workers' Compensation policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

Conformity With State Statutes. Any provision of this Certificate which, on or after the Group Policy Effective Date, is in conflict with the statutes of the state in which **you** reside on such date, is hereby amended to conform to the minimum requirements of such state.

Appeal Procedure

If **we** give notice of an **adverse benefit determination**, the **insured person** may submit an **appeal**. This plan provides for one level of **appeal**.

The **insured person** has 90 calendar days after the receipt of notice of an **adverse benefit determination** to request an **appeal** orally or in writing. The **appeal** must include:

- The **insured person's** name.
- The **policyholder's** name.
- A copy of **our** notice of an **adverse benefit determination**.
- The reasons for making the **appeal**.
- Any other information the **insured person** would like to have considered.

The **insured person** may choose to have another person (an authorized representative) make the **appeal** on their behalf. The **insured person** must provide written consent to **us**.

A review of an **appeal** of an **adverse benefit determination** shall be provided by **our** personnel. They shall not have been involved in making the **adverse benefit determination**.

We shall issue a decision within 60 calendar days of receipt of the request for an **appeal**.

Exhaustion of Process. The **insured person** must exhaust the applicable Appeal Procedure before:

- Contacting the California Department of Insurance to request an investigation of a **complaint** or **appeal** at:

  Consumer Services Division
  300 Spring Street
  South Tower
  Los Angeles CA 90013
  1-800-927-HELP
  1-800-927-4357
- Filing a complaint or **appeal** with the California Department of Insurance; or
- Establishing any:

  - litigation;
  - arbitration; or
  - administrative proceeding;

regarding an alleged breach of the policy terms by **us** or any matter within the scope of the Appeals Procedure.

Termination of Coverage

Termination of Coverage. Your coverage under this Certificate will end, subject to the Portability Provision, on the earliest of the following dates:

- The date **you** cease to be a member of an eligible class;
- The date the eligible class to which the **you** are a member is no longer an eligible class for coverage under the Policy;
- The date **we** receive the **your** written request for termination of coverage;
- The payment due date, if any required premium has not been paid by the end of the grace period;
- The date of **your** death;
- The date the Policy is cancelled or terminated.

Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

Termination of Insured Dependents. An **insured dependent's** coverage under this Certificate will end, subject to the Portability Provision, on the earliest of the following dates:

- The date **your** coverage terminates;
- The date the Policy terminates coverage for all dependents;
- The date an **insured dependent** becomes covered as an employee;
- The date an **insured dependent** is no longer eligible as a dependents;
- For **civil union** partners, the date the Policy no longer allows coverage for **civil union** partners.

Portability Provision

If **your** employment ceases and as a result **your** coverage under the Policy terminates, **we** will provide portability coverage. Such coverage will be available to **you** and any of **your insured dependents**.

You must complete the Portability Coverage Election Form and return it to **us** along with payment the first premium for the portability coverage not later than 30 calendar days after **your** coverage under the Policy terminates. Portability coverage will be effective on the day after benefits under the Policy terminates.

The benefits, terms and conditions of portability coverage will be the same as those provided under the Policy on the date **your** coverage terminated. Any changes made to the Policy after **you** are covered under the Portability Provision will not apply to **you** unless required by law.

The initial premium rates will be based on the premium rates in effect at the time **you** apply for portability coverage. **You** must also pay any portion of the premium previously paid by **your employer** for the coverage.

A grace period of 31 days after the premium due date will be allowed for the payment of each premium. **We** will not pay benefits under this Certificate in the absence of payment of current premium, subject to this grace period.

Portability coverage will end on the earliest of the following dates:

- The date the Policy terminates;
- The date of the **insured person's** death;
- The end of the portability grace period following the date the **insured person** fails to pay the required premium;
- The end of the month on or following the date **you** are again covered under the Policy;
- The date coverage under this Portability Provision is cancelled or terminated by **us** for any reason upon 31 days advanced notice;
- The date **your** class of coverage is terminated;
- With respect to any **insured dependents**:

    - The date **your** coverage terminates;
    - The date **you** and **your insured spouse/civil union partner/domestic partner** divorce, end **your civil union** or domestic partnership;
    - The date **your insured dependent** ceases to be an eligible dependent under the Policy.

An **insured child** whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, or he or she is otherwise eligible.

Once portability coverage is cancelled or terminated, it cannot be reinstated.

Definitions

In this section, **insured persons** will find the definitions for the words and phrases that appear in **bold type** throughout the text of the Certificate/Policy and any attached Riders.

Accident means an unforeseen event, which occurs on or after the effective date of coverage for the **insured person** and while this Certificate is in force, that is the direct cause of an **accidental injury** to an **insured person**.

Accidental injury means bodily injury to an **insured person** that is the proximate cause of an **accident** and is the proximate cause of an injury or loss sustained on or after the **insured person's** effective date of coverage and while this Certificate is in force, which is not excluded under the Policy.

Active-at-work; **actively-at-work**; **active work**; **available-to-work**
You will be considered to be **active-at-work**, **actively-at-work**, **available-to-work** or performing **active work** if, **you** are **available to work** or performing the regular duties of **your** job.

Adverse benefit determination (decision) means a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit. Such **adverse benefit determination** may be based on the **insured person's** eligibility for coverage or coverage determinations, including plan exclusions.

Appeal means an oral or written request to **us** to reconsider an **adverse benefit determination**.

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

Care means medical treatment or attention received in an **emergency room**, **hospital**, **rehabilitation unit**, **urgent care center** or by a **physician** or other licensed health care provider.

Chiropractic care services means spinal manipulation services conducted by a licensed chiropractor to correct a structural imbalance caused by an **accidental injury**. Benefits are not payable for massage therapy or for treatment of chronic conditions or other injuries not related to structural imbalance.

Civil union means a legal relationship between two people of the same or opposite sex that gives them some of the same rights and responsibilities that married people have.

Closed reduction means manipulative, non-surgical, repair of a **fracture** or **dislocation**.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance.

Common carrier means a commercial airlines, train, bus, boat, ferry or ship, subway or streetcar, operated on a regularly scheduled basis between pre-determined ports or cities. Taxis and privately chartered vehicles are not common carriers.

Complaint means any oral or written expression of dissatisfaction about quality of care or the operation of this plan.

Custodial care means services and supplies that are primarily intended to help an **insured person** meet their personal needs. **Care** can be custodial even if it is prescribed by a **physician**, delivered by trained medical personnel, or even if it involves artificial methods (or equipment) such as feeding tubes, monitors, or catheters. **Custodial care** includes; but is not limited to; the following services:

- Changing dressings and bandages; periodic turning and positioning in bed; administering oral medication; watching or protecting an **insured person**.
- Care of a stable tracheostomy (this includes intermittent suctioning).
- Care of a stable colostomy/ileostomy.
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or constant) feeding.
- Care of a stable indwelling bladder catheter (this includes emptying/changing containers and clamping tubing).
- Respite care; adult (or child) day care; or convalescent care.
- Helping an **insured person** perform an activity of daily living, such as: walking; grooming; bathing; dressing; getting in and out of bed; toileting; eating or preparing food.
- Any services that an insured person without medical or paramedical training can perform or be trained to perform.

Diagnosis/diagnosed means a **physician**, specializing in a particular field of medicine, where applicable, has definitively identified an **accidental injury** in an **insured person**. Such **diagnosis** must:

- Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the **insured person's** medical records; and
- Meet all diagnostic requirements stated in the Policy for the particular **accidental injury** being **diagnosed**.

Dislocation means a completely separated joint.

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

- Be staffed and equipped to handle trauma;
- Be supervised and provide **care** by a **physician**;
- Provide **care** 7 days per week, 24 hours per day.

Employee means a person listed as an employee on the books of the **employer** and who is enrolled under the Policy/Certificate.

Employer means the **policyholder**.

Epidural anesthesia means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to an **accidental injury** and does not include epidural steroid injections or treatment for childbirth.

Fracture means a break, rupture or crack in a bone that can be **diagnosed** by X-ray.

Hospital means an institution that:

- Is operated pursuant to law and is licensed as a **hospital** by the responsible state agency;
- Is 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 duly licensed **physicians**, medical, diagnostic and major surgical facilities for the **care** of sick or injured persons on an inpatient basis for which a charge is made; and
- Provides 24-hour nursing services by or under the supervision of registered graduate professional nurses (RNs).

Hospital does NOT mean or include:

- Convalescent, assisted living, extended care, hospice, rest or nursing facilities;
- Facilities primarily affording custodial, educational or rehabilitative **care** or facilities primarily for the aged or for substance abusers; or
- A private monitored room.

Immediate family member means a person who is related to the **insured person** in any of the following ways: spouse, child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law), parents (including stepparent, mother-in-law and father-in-law), and brother or sister (including stepbrother, stepsister, brother-in-law or sister-in-law).

Intensive care unit (ICU) means a place which:

- Is a specifically designated area of the **hospital** that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and **care**;
- Is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient not requiring intensive care;
- Is permanently equipped with special lifesaving equipment for the **care** of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the **ICU** on a 24 hour basis; and
- Has a **physician** assigned to the **ICU** on a full-time basis.

An **intensive care unit** that meets the definition above may include **hospital** units with the following names:

- Intensive Care Unit;
- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit; or
- Transplant Unit.

Insured child(ren) means **your** dependent child(ren) who are enrolled for coverage under the Policy/Certificate.

Insured dependents means **your insured spouse/civil union partner/domestic partner** and **insured child(ren)**.

Insured person means **you** and any **insured dependents**.

Insured spouse/civil union partner/domestic partner means **your** spouse, **civil union** partner or domestic partner who is enrolled for coverage under the Policy/Certificate.

Laceration means a cut or tear in skin or flesh.

Observation unit means a specified area or room within a **hospital**, apart from the **emergency room**, where a patient can be monitored by a **physician** and which:

- Is under the direct supervision of a **physician** or registered nurse (R.N.);
- Is staffed by nurses assigned specifically to that unit; and
- Provides **care** seven days per week, 24 hours per day.

Occupational injury means an **accidental injury** that arises out of (or in the course of) any activity in connection with the **insured person's** employment or self-employment whether or not on a full-time basis or results in any way from an **accidental injury** that does.

Occupational therapist means a person, other than an **insured person** or an **immediate family member** who:

- Possesses the designation "Occupational Therapist Registered (OTR)";
- Is licensed by the State to practice **occupational therapy**;
- Performs services which are allowed by his or her license; and
- Performs services for which benefits are provided under the Policy.

Occupational therapy means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. **Occupational therapy** does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

Open reduction means the surgical repair of a **fracture** or **dislocation**.

Paralysis means injury resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the **insured person's** attending **physician**.

Physical therapist means a person, other than an **insured person** or an **immediate family member** who:

1. Is licensed by the State to practice **physical therapy**;
2. Performs services which are allowed by his or he license;
3. Performs services for which benefits are provided under the Policy; and
4. Practices according to the Code of Ethics of the American Physical Therapy Association.

Physical therapy means treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following injury to or loss of a body part.

Physician means a licensed medical provider, other than the **insured person**, an **immediate family member** or anyone living at the **insured person's** residence, who acts within the scope of his or her license and provides **care** necessary for an **accidental injury**.

Plan year means the period during which benefit maximums accumulate. Each new **plan year**, these maximums reset.

Policyholder means the **employer** who holds the Master Policy.

Rehabilitation unit means an appropriately licensed facility that provides rehabilitation **care** on an inpatient basis. Rehabilitation **care** consists of the combined use of medical, social, educational and vocational services to enable patients disabled by an **accidental injury** to achieve the highest possible functional ability. Services must be provided by or under the supervision of an organized staff of **physician**. The **rehabilitation unit** may be part of a **hospital** or a freestanding facility. A **rehabilitation unit** is not:

- A nursing home;
- An extended care facility;
- A skilled nursing facility;
- A rest home or home for the aged;
- A hospice care facility;
- A place for alcoholics or drug addicts; or
- An assisted living facility.

Second degree burns, also called partial-thickness burns, means the epidermis (outer layer of skin) has been burned through and part of the dermal (second layer of skin) has been burned by heat, electricity, radiation, friction or chemicals. **Second degree burns** do not include burns that result from the skins exposure to the sun.

Sickness means a disease, bodily infirmity, illness, infection or any other physical condition that affects the **insured person**.

Specialist or **subspecialist** means a **physician** whose practice is limited to a particular specialty (or sub-specialty) of medicine or surgery. The **physician** would not routinely provide primary **care** or general **care** for patients.

Speech therapist or **speech pathologist** means a person other than the **insured person** or an **immediate family member** who:

- Is licensed by the State to practice **speech therapy**;
- Performs services which are allowed by his or her license;
- Performs services for which benefits are provided under the Policy; and
- Practices according to the Code of Ethics of the American Speech-Language-Hearing Association.

Speech therapy means treatment and assistance for disorders related to speech, language, cognitive-communication, voice, swallowing and fluency.

Stay means a period during which an **insured person** is confined as an inpatient in a **hospital**, **intensive care unit** or **rehabilitation unit**. **Stay** does not include any period of such a confinement due to **custodial care** or personal needs that do not require medical skills or training. A **stay** excludes time in an **observation unit** or in the **emergency room** unless this leads to a **stay**. Two or more separate **stays** count as one **stay** if they are due to the same **accident**; and they are separated by less than 90 days. Otherwise they count as separate **stays**.

Third degree burns, also called full-thickness burns, means an area of tissue damage in which there is destruction of the entire epidermis (outer layer of skin) and the dermal (second layer of skin) that is caused by heat, electricity, radiation or chemicals.

Urgent care center means a facility operated pursuant to law and licensed by the responsible State agency. Such center is dedicated to the delivery of unscheduled, walk-in care outside of an **emergency room**. The center must be under the supervision of a **physician**.

You, your or **yourself** means the **employee**.

We, company, **us** or **our** means Aetna Life Insurance Company.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between **Aetna** and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Indemnity Benefits for you and your eligible dependents. Your Employer may also allow you to continue other coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage facility indemnity expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Medical Indemnity Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

Additional Information Provided by

NIAGARA BOTTLING LLC

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your *Booklet-Certificate*. Your Plan Administrator has determined that this information together with the information contained in your *Booklet-Certificate* is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Niagara Bottling, LLC.

Employer Identification Number:
33-0843510

Plan Number:
503

Type of Plan:
Off Job Accident Plan

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Niesha Cooper
Niagara Bottling, LLC
2560 East Philadelphia St
Ontario, CA 91761
Telephone Number: 909-786-4047

Agent For Service of Legal Process:
Niagara Bottling, LLC
2560 East Philadelphia St
Ontario, CA 91761

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
February 28th

Source of Contributions:
Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by Niesha Cooper.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

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 your interest and that of 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.

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 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 materials 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 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a federal court.

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.

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, you should contact:

- the nearest office of the Employee Benefits Security 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.

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Limitations and Exclusions under the Arkansas Life and Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

Disclaimer

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/0 The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

Coverage

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity, or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

Exclusions from Coverage
However, persons owning such policies are NOT protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the individual has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); unallocated annuity contracts (which give rights to group contractholders, not individuals); unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

Limits on Amount of Coverage
The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000 in life and annuity benefits and $500,000 in health insurance benefits--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within these overall limits, the Association will not pay more than $ 300,000 in disability and long term care benefits. $500,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $ 300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

NOTICE TO EMPLOYERS

Important Information to Employees
The Arkansas Insurance Department requires that employees located in Arkansas be furnished with a notice advising them who to contact in the event of a question about group insurance. The form that follows entitled "Important Information" is provided to you in compliance with the requirement.

All employees located in Arkansas who are or become covered by your group plan insured by Aetna, should be provided a copy of the form. The form can be distributed in the manner you deem most appropriate.

Important Information
In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2945

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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.caifega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

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

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

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

NOTICES

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

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

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

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

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Notice Of Protection Provided By
Life And Health Insurance
Protection Association

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability protection insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's web site at http://colorado.lhiga.com, email jkelldorf@aol.com or contact:

Colorado Life and Health Insurance
Protection Association
P.O. Box 36009
Denver, CO 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to 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 Colorado law, then Colorado law will control.

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Policyholder Notice:

To: Policyholders with Group Policies Issued in the State of Georgia

Subject: Breast Cancer Patient Care Act

The Georgia legislature has passed HB 604. This law requires us to inform you that:

- Your medical plan provides coverage for inpatient confinements following a mastectomy or a lymph node dissection;
- The length of such confinement will be determined by the attending physician in consultation with the patient; and
- The number of visits required for follow-up care after such surgery will be determined by the attending physician in consultation with the patient.

If you have any questions regarding this notice, please contact your Aetna account representative.

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Notice Of Protection Provided By
The Indiana Life And Health Insurance
Guaranty Association

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA
Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities
- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace Suite
100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

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Notice Concerning Coverage
Limitations And Exclusions Under The North Carolina
Life And Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholder will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

Coverage
Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage
However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- 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 a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C or Part D or any regulations issued pursuant thereto.

Limits on Amount of Coverage
The act also limits the amount the association is obligated to pay out as follows:
(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to basic hospital, medical and surgical insurance and major medical insurance.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

Aetna Life Insurance Company

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Ohio Life And Health Insurance
Guaranty Association
Disclaimer And Not Covered Form

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 West Town Street, Third Floor – Suite 300
Columbus, Ohio 43215

Aetna Life Insurance Company

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Notice Of Protection Provided By
Oklahoma Life And Health Insurance
Guaranty Association Act

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits
- $300.000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to 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 Oklahoma law, then Oklahoma law will control.

To learn more about the above protections, please visit the Association's website at www.oklifega.org or contact:

Oklahoma Life and Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, Oklahoma 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, Oklahoma 73112
Phone: 1-800-522-0071 or (405) 521-2828

Aetna Life Insurance Company

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Texas Life, Accident, Health & Hospital Service
Insurance Guaranty Association

Important Information About Coverage Under The Texas
Life and Health Insurance
Guaranty Association
(For Insurers Declared Insolvent or Impaired on or After September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association
When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association
Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies; up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue,
Suite 1875
Austin, Texas 78701
800-982-6362 or
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439
www.tdi.state.tx.us

Aetna Life Insurance Company

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Notice Of Protection Provided By
Utah Life And Health Insurance
Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
$500,000 in death benefits
$200,000 in cash surrender or withdrawal values

Health Insurance
$500,000 in hospital, medical and surgical insurance benefits
$500,000 in long-term care insurance benefits
$500,000 in disability income insurance benefits
$500,000 in other types of health insurance benefits

Annuities
$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association 's website at www.utlifega.org or contact:

Utah Life and Health
Insurance Guaranty Corporation
60 East south Temple, Suite 500
Salt Lake City, UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City, UT 84114-6901
(801) 538-3800

Aetna Life Insurance Company

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To: Policyholders with Group Policies Issued in the State of Virginia

Subject: Insurance Contact Notice

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits;
- $100,000 in cash surrender or withdrawal values.

Health Insurance
- $500,000 in hospital, medical and surgical insurance benefits;
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law. To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINA LIFE, ACCIDENT
AND SICKNESS
INSURANCE GUARANTY
ASSOCIATION c/o APM
Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION
COMMISSION Bureau of
Insurance
P. O. Box 1157
Richmond, VA 23218-1157

804-371-9741

Toll Free Virginia only:
1-800-552-7945
http://scc.virginia.gov/boi/index.aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to 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 Virginia law, then Virginia law will control.

AETNA LIFE INSURANCE COMPANY

ACCIDENT ONLY

OUTLINE OF COVERAGE

Read Your Certificate Carefully. This outline of coverage provides a very brief description of some important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Aetna. It is, therefore, important that you Read Your Policy Carefully!

Accident Only Coverage. This category of coverage is designed to provide, to persons insured, benefits for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Some notes on how we use words:

- Some words appear in **bold** type. **We** define them in the Glossary section of **your** certificate.
- When we say "**we,**" we mean **Aetna.**
- When we say "**you**" and "**your,**" **we** mean the **employee.**

Benefits of This Policy

Certificate Benefits: If an **insured person** has an **accidental injury**, the applicable benefits shown below are payable subject to the following:

- The benefit maximums, if any, shown on the Schedule of Benefits section of the Certificate;
- A charge must be incurred for the **care** of an **insured person** due to an **accidental injury**;
- The service or supply must be rendered or received due to an **accidental injury** and is not due to or in connection with an **occupational injury**;
- The **accidental injury** must occur while coverage for the **insured person** is in force;
- The service or supply must be rendered or received while coverage for the **insured person** is in force;
- The service or supply must be rendered or received in the United States or its territories; and
- The **accident** must take place in the United States or its territories.

BENEFIT DESCRIPTION	BENEFIT AMOUNT
Accidental Follow-up Benefit	$50
Maximum Visits per **Accident**	2
Maximum Visits per **Plan Year**	6
Ground Ambulance Benefit	$300
Maximum Trips per **Accident**	1
Air Ambulance Benefit	$1,500
Maximum Trips per **Accident**	1
Appliances Benefit	$50
Maximum Appliances per **Accident**	1
Blood/Plasma/Platelets Benefit	$300
Maximum Transfusions per **Accident**	1
Burn Benefit	
Burn Classifications:	
Second Degree Burn, greater than 5% of total body surface	$500
Third Degree Burn, less than 5% of total body surface	$750
Third Degree Burn, 5-10% of total body surface	$3,000
Third Degree Burn, greater than 10% of total body surface	$9,000
Burn Skin Graft Benefit	50% of Burn Benefit
Maximum Skin Grafts per **Accident**	1
Chiropractic Treatment Benefit	$15
Maximum Visits per **Accident**	10
Maximum Visits per **Plan Year**	30
Coma Benefit	$5,000
Maximum Coma per **Accident**	1
Concussion Benefit	$100
Maximum Concussion per **Accident**	1
Dental Treatment Benefit	
Extractions	$50
Crown	$150

Dislocation Benefit	
Closed Reduction	
Hip	$2,000
Knee (except Patella)	$1,000
Ankle - Bone or Bones of the foot (other than toes)	$500
Collarbone (Sternoclavicular)	$400
Lower Jaw (or associated bone joints)	$400
Shoulder (Glenohumera)	$400
Elbow	$400
Wrist	$400
Bone or Bones of the hand (other than fingers)	$400
Collarbone (Acromiociociavicular and separation)	$100
One toe or one finger	$100
Open Reduction	1.5 x Closed Reduction
Maximum Dislocations per **Accident**	1

Eye Injury Benefit	$200
Maximum Visits per **Accident**	1

Fracture Benefit	
Closed Reduction	
Skull (except bones of the face or nose), depressed	$2,750
Skull (except bones of the face or nose), non-depressed	$2,750
Hip, Thigh (Femur)	$1,150
Vertebrae, Body of (excluding Vertebral Processes)	$750
Pelvis (inc. Ilium, Ishicum, Pubis, Acetabulum except Coccyx)	$750
Leg (Tibia and/or Fibula Malleolus)	$750
Bones of the Face or Nose (except Mandible or Maxilla)	$400
Upper Jaw (or associated bone joints), Maxilla (except Alveolar Process)	$400
Upper Arm between Elbow and Shoulder (Humerous)	$400
Lower Jaw (or associated bone joints), Maxilla (except Alveolar Process)	$400
Collarbone, (Clavicle, Sternum)	$400
Shoulder Blade (Scapula)	$400
Vertebral Process	$400
Forearm (Radius and/or Ulna)	$300
Kneecap (Patella)	$300
Hand/Foot (except fingers and toes)	$300
Ankle/Wrist	$300
Rib	$150
Coccyx	$150
Finger, Toe	$150
Open Reduction	1.5x Closed Reduction
Maximum Fractures per **Accident**	1

Hospital Stay - Admission Benefit	
Hospital Admission	$1,000
Maximum Admissions per **Accident**	1
Hospital Stay - Daily Benefit	
Hospital Daily	$100
Maximum Days per **Stay**	365
Maximum **Stays** per **Accident**	1
Rehabilitation Unit Daily	$100
Maximum Days per **Stay**	30
Maximum **Stays** per **Accident**	1
Initial Treatment Benefit - Emergency Room	$100
Maximum Visits per **Accident**	1
Maximum Visits per **Plan Year**	3
Initial Treatment Benefit - Physician's Office or Urgent Care Center	$100
Maximum Visits per **Accident**	1
Maximum Visits per **Plan Year**	3
Laceration Benefit	
Repair Classifications:	
Without stitches	$25
With stitches, less than 7.5 centimeters	$75
With stitches, 7.6 - 20.0 centimeters	$300
With stitches, greater than 20.0 centimeters	$600
Maximum Repairs per **Accident**	1
Lodging Benefit	$100
Maximum Days per **Accident**	30
Medical Imaging Benefit	$100
Maximum Imaging Tests per **Accident**	1
Observation Unit Benefit	$100
Maximum Observations per **Accident**	1
Pain Management (Epidural Anesthesia) Benefit	$50
Maximum Administrations per **Accident**	1
Prosthetic Device/Artificial Limb Benefit	
One Limb	$500
Multiple Limbs	$1,000
Ruptured Disc Benefit	$500
Maximum Repairs per **Accident**	1
Surgery Benefit (with repair)	
Cranial, Open Abdominal & Thoracic	$500
Hernia	$100
Maximum Surgeries (with repair) per **Accident**	1

Surgery Benefit (with no repair)	
Exploratory or Arthroscopic	$100
Maximum Surgeries (with no repair) per **Accident**	1
Tendon/Ligament/Rotator Cuff Benefit	
Surgery for Single Repair	$500
Surgery for Multiple Repairs	$1,000
Maximum Surgeries per **Accident**	1
Therapy Services Benefit - Speech Therapy, Occupational Therapy and Physical Therapy)	$15
Maximum Visits per **Accident**	10
Torn Knee Cartilage Benefit	$500
Maximum Repairs per **Accident**	1
Transportation Benefit	$200
Maximum Round Trips per **Accident**	1
X-ray Benefit	$25
Maximum X-rays per **Accident**	1

Inpatient Hospital Benefit due to Sickness Certificate Rider Benefits: We will pay the applicable benefit shown below if an insured person has a sickness subject to the following:

- The benefit maximums, if any, shown on the Rider Schedule;
- A charge must be incurred for the care of an insured person due to a sickness;
- The service or supply must be rendered or received due to a diagnosed sickness and is not due to or in connection with an occupation sickness;
- The stay must begin on or after the insured person's effective date of coverage under this Rider;
- The service or supply must be rendered or received while coverage for the insured person is in force; and
- The sickness must:

    1. Occur on or after the insured person's effective date of coverage under this Rider;
    2. Occur while this Rider is in force; and
    3. Not be excluded by name or specific description in this Rider.

Hospital Stay Benefits - The Hospital Stay - Admission Benefit and the Hospital Stay - Daily Benefit shown on the Rider Schedule is payable if an insured person has a stay due to a sickness.

Observation Unit Benefit - The Observation Unit Benefit shown on the Rider Schedule is payable if an insured person requires services in an observation unit as the result of a sickness.

Benefit Description	Benefit Amount
Hospital Stay - Admission Benefit	
Hospital Admission	$1,000
Maximum Admissions per Sickness	1
Hospital Stay - Daily Benefit	
Hospital Daily	$100
Maximum Days per **Stay**	365
Maximum **Stays** per **Sickness**	1

Health Screening Certificate Rider Benefit: The Health Screening Benefit shown on the Rider Schedule is payable if an **insured person** has a covered health screening subject to the following:

- A charge must be incurred for the **care** of an **insured person** due to the screening;
- The date of service must occur while coverage for the **insured person** is in force;
- The service or supply must not be rendered or received to **diagnose** or treat a suspected or identified **sickness**; and
-

Benefit Description	Benefit Amount
Health Screening Benefit	$100
Maximum per **Plan Year**	1

Exceptions and Limitations of This Policy:

No benefits are provided for any loss resulting from **sickness** except as payable under the Inpatient Hospital Benefit due to Sickness Certificate Rider.

Certificate Exclusions: Benefits under the Policy will not be payable for any loss or **accidental injury** caused in whole or in part by or resulting in whole or part from the following:

- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a **diagnosed** disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
- Engaging in felony crimes;
- Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection;
- Operating, learning to operate or serving as a crewmember of an aircraft, whether motorized or not;
- Engaging in hang gliding, bungee jumping, parachuting, sail gliding, parasailing, mountaineering using ropes and/or other equipment, or motor-driven vehicle racing;
- Participating in any semi-professional or professional competitive athletic contest, including officiating or coaching, for which the **insured person** receives any compensation or remuneration;
- Services ordered or performed by a **physician**, or supplies purchased from a provider, who is an **insured person**, the **insured person's immediate family member**, or someone who resides with or is employed by or who employs an **insured person**;
- Any form of intentional asphyxiation;
- Elective or cosmetic surgery;
- Bacterial infection that was not caused by a cut or wound from an **accidental injury**.
- **Occupational injuries**.

Also, as to intoxicants and controlled substances: **We** shall not be liable for any loss sustained or contracted in consequence of the **insured person's** being intoxicated or under the influence of any controlled substance unless administered on the advice of a **physician**.

Inpatient Hospital Benefit due to Sickness Certificate Rider Exclusions: Benefits under this Rider will not be payable for any **sickness** caused in whole or in part by or resulting in whole or part from the following:

- **Accidental injuries**;
- Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
- Engaging in felony crimes;
- Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection;
- Services ordered or performed by a **physician**, or supplies purchased from a provider, who is an **insured person**, the **insured person's immediate family member**, or someone who resides with or is employed by or who employs an **insured person**;
- Any form of intentional asphyxiation;
- Outpatient **care**, services, prescription medications or supplies used to treat a **sickness**;
- **Occupational sickness**.

Also:

- **We** will not pay any benefits under this Rider for a newborn child following birth unless the child is sick; and

- As to intoxicants and controlled substances: **We** shall not be liable for any loss sustained or contracted in consequence of the **insured person's** being intoxicated or under the influence of any controlled substance unless administered on the advice of a **physician**.

Inpatient Hospital Benefit due to Sickness Certificate Rider Limitations:

- **Giving Birth - We** will not pay any benefits under this Rider due to an **insured person** giving birth within the first nine (9) months after the **insured person's** effective date of coverage under this Rider as a result of a normal pregnancy, including cesarean. **Complications of pregnancy** will be covered to the same extent as a **sickness**.

Renewability of This Policy. The policy is optionally renewable.

Portability: If **your** employment ceases and as a result **your** coverage under the policy terminates, **we** will provide portability coverage. Such coverage will be available to **you** and any of **your insured dependents**. See the Portability Provision section of the certificate for details.

Premium for This Policy. Total premium payable by the **insured person** for the coverage is.

Level	Weekly	Bi-Weekly	Semi-Monthly	Monthly
EE				
	$3.26	$6.52	$7.06	$14.11
EE+SP				
	$6.53	$13.06	$14.16	$28.31
Family				
	$11.86	$23.72	$25.70	$51.39
EE+CH				
	$8.23	$16.46	$17.82	$35.65

Premium shall be paid by payroll deduction.

Group Accident Policy

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

The words which appear in **bold** type are defined in the Definitions section of the Certificate.

Policyholder:	NIAGARA BOTTLING LLC
Group Policy Number:	802363
Effective Date:	March 1, 2018
Term of Policy:	The Initial Term shall be: The 12 consecutive month period beginning on the March 1st. Thereafter, Subsequent Terms shall be: The 12 consecutive month period beginning on March 1st of each year.
Date of Issue:	December 18, 2017
Policy delivered in:	California

We agree to provide benefits under this Policy to **insured persons**, in consideration of the application for this Policy and the timely payment of premiums, and subject to the terms and conditions, exclusions and any limitations of this Policy.

The law of the jurisdiction in which this Policy is delivered will apply to this Policy.

The provisions on the following pages and the terms on the attached Certificate and any attached amendment(s) or Rider(s) are a part of this Policy.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

The **policyholder** has 10 days from the date of delivery of this Policy to examine it. If the **policyholder** is not satisfied for any reason, this Policy may be returned within 10 days to **us** at **our** home office or to the writing agent. **We** will refund the premium paid and this Policy will be void from its beginning.

This Policy is a non-participating Policy and does not share in the company's surplus.

THIS IS A LIMITED POLICY. IT PROVIDES BENEFITS FOR ACCIDENTS.

LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH THE INSURED PERSON'S TAXES.

The benefit payments are not intended to cover the full cost of medical care. Insured persons are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage the insured person may have.

THIS POLICY IS NOT IN LIEU OF AND DOES NOT AFFECT ANY REQUIREMENT FOR COVERAGE BY WORKMENT'S COMPENSATION INSURANCE.

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

This plan does not count as minimum essential coverage under the Affordable Care Act.

PLEASE READ THIS POLICY CAREFULLY

Signed for Aetna Life Insurance Company.
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Table of Contents

Eligible Classes

All classes of **employees** defined in this Policy are eligible. An **employee** is eligible only for the coverage shown in the Certificate which applies to his or her class.

Premium Provisions

PREMIUM RATES: The current premium rates for all of the benefits provided under this Policy are on record with both **us** and the **policyholder**.

PREMIUM PAYMENTS: Premiums will be paid in advance. They may be paid to SRC Premium Trust, PO Box 536919, Atlanta GA 30353-6919 or by agreed upon electronic means or to **our** authorized agent.

A premium is due to be paid on the 15 of each month ("premium due date").
GRACE PERIOD: Refer to the Grace Period provision under the General Provisions section below.

PREMIUM CHANGES: The premium rates may be changed by **us**. If the rates are changed, **we** will give at least 31 days advance written notice.

RETURN OF PREMIUMS: In the event of termination of this Policy, **we** shall promptly return on a pro-rata basis the unearned premium paid, if any, and the **policyholder** shall promptly pay on a pro-rata basis the earned premium.

UNPAID PREMIUM: Any unpaid premium due under this Policy may be recovered by **us** by offsetting against amounts otherwise payable under this Policy.

Termination Provisions

TERMINATION BY POLICYHOLDER: This Policy may be terminated by the **policyholder**. The **policyholder** may terminate this Policy as to all or any class of its **employees**. **We** must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to **us** for the coverage.

TERMINATION BY US: **We** may terminate this Policy at any time following the Initial Term by giving the **policyholder** written notice at least 31 days in advance. This Policy will also terminate if the required premium is not paid by the **policyholder** as provided in the Grace Period provision.

General Provisions

ENTIRE CONTRACT; CHANGES: This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an **Aetna** executive officer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the **policyholder** in the application for this Policy shall be used to void the Policy or to deny a claim for loss incurred commencing after the expiration of the two-year period.

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

GRACE PERIOD: Unless not less than five days prior to the premium due date **we** have delivered to the **policyholder** or has mailed to his last address as shown by **our** records written notice of its intention not to renew this Policy beyond the period of which the premium has been accepted, a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period this Policy shall continue in force (subject to **our** right to termination in accordance with the Termination Provisions above).

REINSTATEMENT: If any renewal premium be not paid within the time granted the **covered person** for payment, a subsequent acceptance of premium by **us** or by any agent duly authorized by **us** to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if **we** or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by **us** or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless **we** have previously notified the **covered person** in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such **accidental injury** as may begin more than 10 days after such date. In all other respects the **covered person** and **us** shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to **us** within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the **covered person** or the beneficiary to the **covered person** at Aetna Voluntary, P.O. Box 14079, Lexington, KY 40512-4079, or to any of **our** authorized agents, with information sufficient to identify the **covered person**, shall be deemed notice to **us**.

CLAIM FORMS: **We**, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to **us** at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Proof of loss includes a completed and signed claim form and any supporting documentation from the **insured person's physician**.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss.

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the **covered person**. Any other accrued indemnities unpaid at the **covered person's** death may, at **our** option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the **covered person**.

If any indemnity of this Policy shall be payable to the estate of the **covered person**, or to a **covered person** or beneficiary who is a minor or otherwise not competent to give a valid release, **we** may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the **covered person** or beneficiary who is deemed by **us** to be equitably entitled thereto. Any payment made by **us** in good faith pursuant to this provision shall fully discharge **us** to the extent of such payment.

PHYSICAL EXAMINATIONS AND AUTOPSY: **We** at **our** own expense shall have the right and opportunity to examine the person of the **covered person** when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

CHANGE OF BENEFICIARY: Unless the **covered person** makes an irrevocable designation 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.

ADDITIONAL INSURED PERSONS: Additional **insured persons** may be added to this Policy, in accordance with this Policy's provisions.

CERTIFICATES: **Our** method of providing the **policyholder** with individual Certificates will be electronic for the **policyholder's** delivery to their **employees**. However, **we** will provide a supply of paper copies upon request. These should be made available or delivered to each **insured person** by the **policyholder**. The insurance in force will be set forth in the Certificate. Statements as to whom benefits are payable will appear.

MISSTATEMENT OF AGE: If the age of the **insured person** has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age. If, according to the correct age, the coverage would not have become effective, **our** liability shall be limited to the refund of all premiums paid for the period not covered.

CLERICAL ERROR OR OMISSION: Clerical error or omission by **us** will not:

- Prevent an **insured person** from receiving coverage;
- Affect the amount of an **insured person's** coverage; or
- Cause an **insured person's** coverage to begin or continue when coverage would otherwise not be effective.

NECESSARY INFORMATION: We must receive any and all information necessary for the enrollment and determination of eligibility of the **Policyholder's employees**, including any covered dependents.

NON-DISCRIMINATION: In the management of this Policy, the **policyholder** will act so as not to discriminate unfairly between persons in like situations at the time of the action. **We** can rely on such action. **We** will not have to probe into the details.

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

Inpatient Hospital Benefit due to Sickness Certificate Rider

Policyholder:	NIAGARA BOTTLING LLC
Group Policy No.:	802363
Issue Date:	December 18, 2017
Group Policy Effective Date:	March 1, 2018
Plan Year	March 1st to February 28th

This Certificate Rider is made a part of the Certificate to which it is attached. It is subject to the definitions, provisions, exclusions and conditions of the Certificate to which it is attached and which are not inconsistent with the provisions of this Rider.

RIDER SCHEDULE

Benefit Description	Benefit Amount
Hospital Stay - Admission Benefit	
Hospital Admission	$1,000
Maximum Admissions per Sickness	1
Hospital Stay - Daily Benefit	
Hospital Daily	$100
Maximum Days per **Stay**	365
Maximum **Stays** per **Sickness**	1

RIDER BENEFIT

We will pay the applicable benefit shown on the Rider Schedule if an insured person has a sickness subject to the following:

1. The benefit maximums, if any, shown on the Rider Schedule;
2. A charge must be incurred for the care of an insured person due to a sickness;
3. The service or supply must be rendered or received due to a diagnosed sickness and is not due to or in connection with an occupation sickness;
4. The stay must begin on or after the insured person's effective date of coverage under this Rider;
5. The service or supply must be rendered or received while coverage for the insured person is in force; and
6. The sickness must:

    - Occur on or after the insured person's effective date of coverage under this Rider;
    - Occur while this Rider is in force; and
    - Not be excluded by name or specific description in this Rider.

Hospital Stay Benefits
We will pay the Hospital Stay - Admission Benefit and the Hospital Stay - Daily Benefit shown on the Rider Schedule if an insured person has a stay due to a sickness.

Observation Unit Benefit
We will pay the Observation Unit Benefit shown on the Rider Schedule if an insured person requires services in an observation unit as the result of a sickness.

RIDER EXCLUSIONS

Exclusions: Benefits under this Rider will not be payable for any sickness caused in whole or in part by or resulting in whole or part from the following:

1. Accidental injuries;
2. Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
3. Engaging in felony crimes;
4. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection;
5. Services ordered or performed by a physician, or supplies purchased from a provider, who is an insured person, the insured person's immediate family member, or someone who resides with or is employed by or who employs an insured person;
6. Any form of intentional asphyxiation;
7. Outpatient care, services, prescription medications or supplies used to treat a sickness.
8. **Occupational sickness**.

Also:

- We will not pay any benefits under this Rider for a newborn child following birth unless the child is sick; and
- As to intoxicants and controlled substances: **We** shall not be liable for any loss sustained or contracted in consequence of the **insured person's** being intoxicated or under the influence of any controlled substance unless administered on the advice of a **physician**.

RIDER DEFINITIONS

In this section, insured persons will find the definitions for the words and phrases that appear in bold type throughout the text of this Rider.

Complication of pregnancy means:

1. Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Complication of pregnancy does not include morning sickness, hyperemesis gravidarum, false labor, occasional spotting, physician prescribed rest during the period of pregnancy, pre-eclampsia or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Diagnosis/diagnosed means a physician, specializing in a particular field of medicine, where applicable, has definitively identified a sickness in an insured person. Such diagnosis must:

1. Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the insured person's medical records; and
2. Meet all diagnostic requirements stated in the Policy for the particular sickness being diagnosed.

Occupational sickness means a sickness that:

1. Arises out of (or in the course of) any activity in connection with the insured person's employment or self-employment whether or not on a full time basis; or
2. Results in any way from a sickness that does.

RIDER TERMINATION

This Rider will terminate on the earliest of:

1. The date we receive your written request to terminate this Rider;
2. The end of the grace period following the date any required premium for this Rider has not been paid; or
3. The date the Certificate to which this Rider is attached terminates.

RIDER PREMIUMS

While this Rider is in effect, premiums are due and may be changed according to the terms of the Certificate.

Signed for Aetna Life Insurance Company.
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

Health Screening Benefit Certificate Rider

Policyholder:	NIAGARA BOTTLING LLC
Group Policy No.:	802363
Issue Date:	December 18, 2017
Group Policy Effective Date:	March 1, 2018
Plan Year	March 1st to February 28th

This Certificate Rider is made a part of the Certificate to which it is attached. It is subject to the definitions, provisions, exclusions and conditions of the Certificate to which it is attached and which are not inconsistent with the provisions of this Rider.

RIDER SCHEDULE

Benefit Description	Benefit Amount
Health Screening Benefit	$100
Maximum per **Plan Year**	1

RIDER BENEFIT

We will pay the Health Screening Benefit shown on the Rider Schedule if an **insured person** has a health screening subject to the following:

- A charge must be incurred for the **care** of an **insured person** due to the screening.
- The date of service must occur while coverage for the **insured person** is in force.
- The service or supply must not be to **diagnose** or treat a suspected or identified **sickness**.

Health Screening Benefit

We will pay the Health Screening Benefit shown on the Rider Schedule if an **insured person** has any of the following health screening tests performed:

Lipoprotein profile (serum plus HDL, LDL and triglycerides)	Skin cancer screening
Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)	Serum protein electrophoresis (blood test for myeloma)
Fasting blood glucose test	Prostate Specific Antigen (PSA) Test
Carotid Doppler Ultrasound	Flexible sigmoidoscopy
Electrocardiogram (EKG, ECG)	Digital rectal exams (DRE)
Echocardiogram (ECHO)	Hemoccult stool analysis
Chest x-ray (CXR)	Colonoscopy
Thermography	Virtual colonoscopy
Ultrasound screening for abdominal aortic aneurysms	Carcinoembryonic Antigen (CEA)
Bone marrow screening	Cancer Antigen (CA) Test 15-3 (breast cancer)
Adult and child immunizations	Mammography
HPV vaccine (Human Papillomavirus)	Breast Ultrasound
Bone mass density measurement (DEXA, DXA)	Cancer Antigen (CA) Test 125 (ovarian cancer)
	Pap smears
	Cytological Screening
	ThinPrep Pap Test

NOTICE OF CLAIM

In addition to the Notice of Claim provision in the Certificate, notice of claim for the benefit under this Rider may also be submitted orally.

RIDER TERMINATION

This Rider will terminate on the earliest of:

1. The date **we** receive **your** written request to terminate this Rider;
2. The end of the grace period following the date any required premium for this Rider has not been paid; or
3. The date the Certificate to which this Rider is attached terminates.

RIDER PREMIUMS

While this Rider is in effect, premiums are due and may be changed according to the terms of the Certificate.

Signed for Aetna Life Insurance Company.
(A Stock Company)

Mark T. Bertolini
Chairman, Chief Executive Officer and President