Questions or Complaints about Your Coverage

In the event you have questions or complaints regarding any aspect of your coverage, you should contact your Employee Benefits Manager or you may write to us at:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call us at: 1-800-523-2233
When calling, please give us the following information:
1) the policy number; and
2) the name of the policyholder (employer or organization), as shown in your Certificate of Insurance.

Or you may contact our Sales Office:
Hartford Life and Accident Insurance Company
Group Sales Department
7400 College Blvd
Ste 500
Overland Park, KS 66210
TOLL FREE: 800-828-1129
FAX: 913-693-2950

If you have a complaint, and contacts between you and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require we provide you with additional contact information:

<table>
<thead>
<tr>
<th>For Residents of:</th>
<th>Write</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>Arkansas Insurance Department&lt;br&gt;Consumer Services Division&lt;br&gt;1200 West Third Street&lt;br&gt;Little Rock, AR 72201-1904</td>
<td>1(800) 852-5494&lt;br&gt;1(501) 371-2640 (in the Little Rock area)</td>
</tr>
<tr>
<td>California</td>
<td>State of California Insurance Department&lt;br&gt;Consumer Communications Bureau&lt;br&gt;300 South Spring Street, South Tower&lt;br&gt;Los Angeles, CA 90013</td>
<td>1(800) 927-HELP</td>
</tr>
<tr>
<td>Idaho</td>
<td>Idaho Department of Insurance&lt;br&gt;Consumer Affairs&lt;br&gt;700 W State Street, 3rd Floor&lt;br&gt;PO Box 83720&lt;br&gt;Boise, ID 83720-0043</td>
<td>1-800-721-3272 or <a href="http://www.DOI.Idaho.gov">www.DOI.Idaho.gov</a></td>
</tr>
<tr>
<td>Illinois</td>
<td>Illinois Department of Insurance&lt;br&gt;Consumer Services Station&lt;br(Springfield, Illinois 62767)</td>
<td>Consumer Assistance: 1(866) 445-5364&lt;br&gt;Officer of Consumer Health Insurance: 1(877) 527-9431</td>
</tr>
<tr>
<td>Indiana</td>
<td>Public Information/Market Conduct&lt;br&gt;Indiana Department of Insurance&lt;br&gt;311 W. Washington St. Suite 300&lt;br&gt;Indianapolis, IN 46204-2787</td>
<td>Consumer Hotline: 1(800) 622-4461&lt;br&gt;1(317) 232-2395 (in the Indianapolis Area)</td>
</tr>
<tr>
<td>Virginia</td>
<td>Life and Health Division&lt;br&gt;Bureau of Insurance&lt;br&gt;P.O. Box 1157&lt;br&gt;Richmond, VA 23209</td>
<td>1(804) 371-9741 (inside Virginia)&lt;br&gt;1(800) 552-7945 (outside Virginia)</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Office of the Commissioner of Insurance&lt;br&gt;Complaints Department</td>
<td>1(800) 236-8517 (outside of Madison)&lt;br&gt;1(608) 266-0103 (in Madison)</td>
</tr>
</tbody>
</table>
The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona
This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read This certificate carefully.

Florida
The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida.

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

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

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

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Montana
The benefits of the policy providing your coverage are governed primarily by the law of a state other than Montana.

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

North Carolina
UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGE, AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON’S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.

THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.
**IMPORTANT NOTICE**

To obtain information or make a complaint:

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

1-800-523-2233

You may also write to The Hartford at:

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

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

**PREMIUM OR CLAIM DISPUTES:**

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

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

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**Texas**

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al:

1-800-523-2233

Usted tambien puede escribir a The Hartford:

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

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.tx.us

**DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU POLIZA:**
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.
CERTIFICATE OF INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

Policyholder: Associated Colleges of the Midwest - Carleton College
Policy Number: 91-ADD-S07734
Policy Effective Date: January 1, 2014
Policy Anniversary Date: January 1, 2014

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

Signed for the Company

Terence Shields, Secretary
Michael Concannon, Executive Vice President

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

Table of Contents
Schedule of Insurance
Period of Coverage
Benefits
Exclusions
General Provisions
Definitions
Amendatory Rider
SCHEDULE OF INSURANCE

AMENDMENT TO GROUP POLICY 91-ADD-S07734 PROCESSED ON SEPTEMBER 25, 2015. ANY CHANGES BETWEEN THIS POLICY AND THE PREVIOUSLY ISSUED POLICY ARE EFFECTIVE JANUARY 1, 2016.

Cost of Coverage:
Contributory Coverage: Supplemental Accidental Death and Dismemberment Insurance
Supplemental Dependents' Accidental Death and Dismemberment Insurance

Eligible Class(es) For Coverage: All Active Employees who are salaried or hourly in active employment who are benefit eligible as determined by Your Employer and who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal employees.

Full-time Employees: at least 20 hours weekly.

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
1) None - if You are working for the Employer on the Policy Effective Date.
2) The first day of the month following the date You were hired - if You start working for the Employer after the Policy Effective Date.

The time periods referenced above are continuous.

Accidental Death and Dismemberment Benefit (AD&D)

Supplemental AD&D Principal Sum

Principal Sum

The Principal Sum applicable to You is the amount for which:
 a) You are eligible to request as determined below;
 b) You have given us a Written Request; and
 c) the required premium is paid.

Principal Sum Amount:

Minimum Amount: $10,000
Maximum Amount: $500,000
Increments of: $10,000

The Principal Sum requested cannot exceed the lesser of 10 times Your Earnings or the maximum above.

Accidental Death and Dismemberment Reduction on and after Age 70: We will reduce Your or Your Spouse’s Principal Sum on the Anniversary date on or next following the date You attain ages 70, 75, 80 and 85. The reduced amount will be determined by multiplying the Principal Sum shown in the Schedule by the percentage shown below for Your attained age:

<table>
<thead>
<tr>
<th>Your Age</th>
<th>Percentage of Principal Sum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 70 - 74</td>
<td>65%</td>
</tr>
<tr>
<td>Age 75 - 79</td>
<td>45%</td>
</tr>
<tr>
<td>Age 80 - 84</td>
<td>30%</td>
</tr>
<tr>
<td>Age 85 or over</td>
<td>15%</td>
</tr>
</tbody>
</table>

These reductions also apply if:
1) You become covered under The Policy; or
2) Your coverage increases; on or after the date You attain age 70.
**Principal Sum for each of Your Eligible Dependents**

The Principal Sum that applies to each person covered under The Policy as Your Dependent, on the date of accident, is determined by multiplying Your Principal Sum by the percentage determined below.

<table>
<thead>
<tr>
<th></th>
<th>Spouse only</th>
<th>Spouse and Dependent Child(ren)</th>
<th>Dependent Child(ren) only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each Dependent Child</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Principal Sum for any one Child cannot exceed the lesser of the amount calculated above or $50,000.

**Additional Benefits**

**Seat Belt Coverage:**
Seat Belt Benefit Amount: 10% of Principal Sum to a maximum amount of $50,000
Minimum Benefit: $3,000

**Rehabilitation Benefit:**
Maximum Amount: $10,000
Rehabilitation Benefit Percentage: 10%

**Continuation of Medical Coverage (COBRA) Benefit:**
Maximum Benefit Amount: $1,000
Minimum Benefit Amount: $500
Percentage for the Continuation of Medical Coverage Benefit: 5%

**Common Disaster Benefit:**
Common Disaster Limit: $1,000,000

**Dependent Child Dismemberment Benefit**

**Permanent Total Disability Benefit:**
Disability Commencement Period: 365 day(s)
Qualification Period: 12 month(s)
Benefit Amount: See Principal Sum Amount

**ELIGIBILITY AND ENROLLMENT**

**Eligible Persons:** *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

**Eligibility for Coverage:** *When will I become eligible?*
You will become eligible for coverage on the latest of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for coverage shown in the Schedule of Insurance, if applicable.

**Eligibility for Dependent Coverage:** *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become insured for employee coverage; or
2) the date You acquire Your first Dependent.
You may not cover Your Dependent if such Dependent is covered as an Employee under The Policy. No person can be insured as a Dependent of more than one Employee under The Policy.

**Enrollment: How do I enroll for coverage?**
You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.

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

**Change in Family Status: What constitutes a Change in Family Status?**
A Change in Family Status occurs when:
  1) You get married or You execute a domestic partner affidavit;
  2) You and Your spouse divorce or terminate a domestic partnership;
  3) Your child is born or You adopt or become the legal guardian of a child;
  4) Your spouse or domestic partner dies;
  5) Your child is no longer financially dependent on You or dies;
  6) Your spouse is no longer employed, which results in a loss of group insurance; or
  7) You have a change in classification from part-time to full-time or from full-time to part-time.

**PERIOD OF COVERAGE**

**Effective Date: When does my coverage start?**
Coverage will start on the latest to occur of:
  1) the date You become eligible, if You enroll on or before that date;
  2) the Policy Anniversary Date on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period;
  3) the date You enroll if You do so within 31 days of the date You are eligible.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

**Deferred Effective Date: When will my effective date for coverage or a change in my coverage be deferred?**
If, on the date You are to become covered:
  1) under The Policy;
  2) for increased benefits; or
  3) for a new benefit;
You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

**Continuity from a Prior Policy: Is there Continuity of Coverage from a Prior Policy?**
Your initial coverage under The Policy will begin, and will not be deferred if on the day before the Effective Date, You were insured under the Prior Policy, but on the Effective Date, You were not Actively at Work, but would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the amount of accidental death and dismemberment principal sum:
  1) You had under the Prior Policy; or
  2) shown in the Schedule of Insurance;
reduced by any coverage amount:
  1) that is in force, paid or payable under the Prior Policy; or
  2) that would have been so payable under the Prior Policy had timely election been made.

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

Coverage provided through this provision ends on the first to occur of:
  1) the last day of a period of 12 consecutive months after the Effective Date;
  2) the date Your insurance terminates for any reason shown under the Termination provision;
  3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
  4) the date You are Actively at Work.
However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

**Dependent Effective Date: When does Dependent coverage start?**
Contributory Coverage will start on the latest to occur of:
1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the Policy Anniversary Date on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

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

**Dependent Deferred Effective Date: When will the effective date for Dependent coverage or a change in coverage be deferred?**
If, on the date Your Dependent is to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;
he or she is:
1) confined in a hospital; or
2) Confined Elsewhere;
such coverage will not start until he or she:
1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;
and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Children.

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

**Dependent Continuity from a Prior Policy: Is there Continuity of Coverage from a Prior Policy for my Dependents?**
If on the day before the Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the amount of accidental death and dismemberment insurance:
1) they had under the Prior Policy; or
2) shown in the Schedule of Insurance;
reduced by any coverage amount:
1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

**Change in Coverage: When may I change my coverage or Coverage for my Dependents?**
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:
1) during any Annual Enrollment Period designated by the Policyholder; or
2) within 31 days of the date of a Change in Family Status.

**Effective Date for Changes in Coverage: When will changes in coverage become effective?**
Any decrease in coverage will take effect on the date of the change. Any increase in coverage will take effect on the date of the change.

**Termination: When will my coverage end?**
Your coverage will end on the earliest of the following:
1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or the Policy no longer covers Your class;
3) the date the required premium is due but not paid;
4) the date Your Employer terminates Your employment;
5) the date You are no longer Actively at Work;
unless continued in accordance with one of the Continuation Provisions.
Dependent Termination:  When does coverage for my Dependent end?
Coverage for Your Dependent will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent.
unless continued in accordance with the continuation provisions.

Continuation Provisions:  Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.  Coverage may not be continued under more than one Continuation Provision.
The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended.  Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.
In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions.
In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence:  If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued for 3 month(s).  If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

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

Lay Off:  If You are temporarily laid off by the Employer due to lack of work, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued for 18 month(s).  If the lay-off becomes permanent, this continuation will cease immediately.

Disability Insurance:  If You are working for the Policyholder and:
1) are covered by; and
2) meet the definition of disabled under;
a Group Disability Insurance Policy, issued by Us to Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued until the last day of the 12th month after the month in which You became disabled, as defined in the Group Disability Insurance Policy.

Sickness or Injury:  If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Accidental Death and Dismemberment coverage) may be continued:
1) for a period of twelve consecutive months from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state and/or federal family and medical leave laws, then the combined continuation period will not exceed twelve consecutive months.

Family and Medical Leave:  If You are granted a leave of absence, in writing, in accordance with state and/or federal family and medical leave laws, all of Your coverages (including Dependent Accidental Death and Dismemberment coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your insurance would have terminated.  If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Sabbatical:  If You are on a documented paid sabbatical, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued for 12 month(s) after the sabbatical commenced.  If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.

Spouse Continuation:  Can coverage for my Spouse be continued in the event of my death?
If You die while Your Spouse is covered under The Policy, Your surviving Spouse may continue:
1) his or her coverage; and
2) coverage of Your Dependent Child(ren) who were covered by The Policy on the date of Your death.
We must receive Your Spouse’s written request and the required premium to continue the coverage within 31 days of the
Premium Due Date next following the date of Your death.

Solitary for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your
Spouse’s or any of the Dependent Child(ren)’s coverage will not continue beyond:
1) a date the coverage would otherwise have ended under the Dependent Termination provision; or
2) the Premium Due Date next following the date Your Spouse remarries.

**Dependent Continuation:** Can coverage for my Dependents be continued if I die?
If You die while insured under The Policy, the Accidental Death and Dismemberment Insurance coverage for Your
Dependents in force at the time of Your death may be continued, until the earliest of:
1) the date the coverage would otherwise have ended under the Dependent Termination provision;
2) the date Your Spouse remarries, dies, or obtains coverage under another group plan; or
3) 5 years from Your date of death.

Coverage continued under this provision will be Contributory Coverage and may not be increased.

**Continuation for Dependent Child(ren) with Disabilities:** Will coverage for Dependent Children with Disabilities be
continued?
If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:
1) age 19 or older; and
2) disabled; and
3) primarily dependent upon You for financial support;
then Dependent Child(ren) coverage will not terminate solely due to age. However:
1) You must submit proof satisfactory to Us of such Dependent Child(ren)’s disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child(ren) must have become disabled before attaining age 19.

Coverage under The Policy will continue as long as:
1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.
However, no increase in the Amount of Dependent Accidental Death and Dismemberment Insurance for such Dependent
Children will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that
the child continues to meet these conditions. We will not require proof more often than once a year after that.

**Reinstatement after Military Service:** Can my coverage be reinstated after return from active military service?
If:
1) Your coverage terminates because You enter active military service; and
2) You are rehired within 12 months of the date Your coverage terminated;
then coverage for You and Your previously covered Spouse/Dependents may be reinstated, provided You request such
reinstatement within 31 days of the date You return to work.

The reinstated coverage will be the same coverage amounts in force on the date coverage terminated and will be subject
to all the terms and provisions of The Policy.

**BENEFITS**

**Accidental Death and Dismemberment Benefit:** When is the Accidental Death and Dismemberment Benefit payable?
If You or Your Dependents sustain an Injury that results in any of the following Losses within 90 days of the date of
accident, We will pay the injured person’s amount of Principal Sum, or a portion of such Principal Sum, as shown opposite
the Loss after We receive Proof of Loss, in accordance with the Proof of Loss provision.
This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance. The amount of Your Dependent’s Principal Sum is shown as a percentage of Your Principal Sum in the Schedule of Insurance.

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Benefit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Speech and Hearing in Both Ears</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Either Hand or Foot and Sight of One Eye</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Movement of Both Upper and Lower Limbs (Quadriplegia)</td>
<td>Principal Sum</td>
</tr>
<tr>
<td>Movement of Both Lower Limbs (Paraplegia)</td>
<td>Three-Quarters of Principal Sum</td>
</tr>
<tr>
<td>Movement of Three Limbs (Triplegia)</td>
<td>Three-Quarters of Principal Sum</td>
</tr>
<tr>
<td>Movement of the Upper and Lower Limbs of One Side</td>
<td>One-Half of Principal Sum</td>
</tr>
<tr>
<td>of the Body (Hemiplegia)</td>
<td>One-Half of Principal Sum</td>
</tr>
<tr>
<td>Either Hand or Foot</td>
<td>One-Half of Principal Sum</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>One-Half of Principal Sum</td>
</tr>
<tr>
<td>Speech or Hearing in Both Ears</td>
<td>One-Half of Principal Sum</td>
</tr>
<tr>
<td>Movement of One Limb (Uniplegia)</td>
<td>One-Quarter of Principal Sum</td>
</tr>
<tr>
<td>Thumb and Index Finger of Either Hand</td>
<td>One-Quarter of Principal Sum</td>
</tr>
</tbody>
</table>

Loss means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

Exposure and Disappearance: What if Loss is due to exposure or disappearance?
Exposure to the elements will be presumed to be Injury if:
1) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You or Your Dependents were an occupant at the time of the accident; and
2) The Policy would have covered an Injury resulting from the accident.

We will presume that You or Your Dependents suffered Loss of life if:
1) the person’s body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
2) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
3) The Policy would have covered an Injury resulting from the accident.

Seat Belt Benefit: When is the Seat Belt Benefit payable?
If You sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt Benefit if the Injury occurred while You were:
1) a passenger riding in; or
2) the licensed operator of;
a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Seat Belt Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.
**Accident**, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

**Seat Belt** means:
1) an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle’s manufacturer’s specifications; or
2) a child restraint device that meets the standards of the National Safety Council and is properly secured and used in accordance with applicable state law and installed according to the recommendations of its manufacturer for children of like age and weight.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Rehabilitation Benefit:**  *When is the Rehabilitation Benefit payable?*
If You sustain an Injury that results in a Loss other than Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Rehabilitation Benefit for Rehabilitative Program Expenses Incurred within one (1) year of the date of accident.

This Benefit will be paid:
1) after We receive proof of Expenses Incurred for a Rehabilitative Program, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Rehabilitation Benefit provides an amount equal to the least of:
1) the actual Expense Incurred for a Rehabilitative Program;
2) the amount resulting from multiplying Your amount of Principal Sum by the Rehabilitation Benefit Percentage; or
3) the Maximum Amount for this Benefit.

**Rehabilitative Program** means any training which:
1) is required due to Your Injury; and
2) prepares You for an occupation for which You were not previously trained.

**Expense Incurred** means the actual cost of:
1) training; and
2) materials needed for the training.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Common Disaster Benefit:**  *When is the Common Disaster Benefit payable?*
If You and Your Spouse die as the result of Injury:
1) received in the same accident; or
2) in separate accidents which occur within 24 hours of each other;

and a Principal Sum is payable under the Accidental Death and Dismemberment Benefit for each death, the Principal Sum applicable to Your Spouse will be increased to equal the lesser of:
1) Your Principal Sum; or
2) an amount which, when added to Your Principal Sum, equals the Common Disaster Limit.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

**Permanent Total Disability Benefit:**  *When is the Permanent Total Disability Benefit payable?*
If You are Disabled and Your Disability:
1) resulted from Injury You received before You attained the Age Limit;
2) began within the Disability Commencement Period after the accident;
3) continued without interruption for at least the Qualification Period; and
4) is reasonably expected to continue without interruption until You die;

We will pay the Benefit Amount, less any amount paid or payable under the Accidental Death and Dismemberment Benefit.
This Benefit will be paid:
1) after We receive Proof of Loss while You are alive, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

Disabled or Disability, for the purpose of this Benefit, means:
1) during the first two years of disability, Your inability to perform the Essential Duties of Your Occupation; and
2) after that, Your inability to engage in Any Occupation for which you are suited by education, training and experience.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

EXCLUSIONS

Exclusions: What losses are not covered?
The Policy does not cover any loss caused or contributed to by:
1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) war or act of war, whether declared or not;
4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
   (We will refund the pro rata portion of any premium paid for You or Your Dependents while You or Your Dependents are in the armed forces on full-time active duty, for a period of two months or more. Written notice must be given to Us within 12 months of the date You or Your Dependents enter the armed forces);
5) Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6) Injury sustained while On any aircraft:
   a) as a pilot, crewmember or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy;
   d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
7) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds; or
8) Injury sustained while committing or attempting to commit a felony.

Intoxicated means:
1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;
that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

GENERAL PROVISIONS

Notice of Claim: When should I notify the Company of a claim?
You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 20 days after:
1) the date of death; or
2) the date of loss.
If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant’s name, address and the Policy Number.

Claim Forms: Are special forms required to file a claim?
We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: What is Proof of Loss?
Proof of Loss may include, but is not limited to, the following:

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
6) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
7) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
8) Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: When must Proof of Loss be given?
Written Proof of Loss must be sent within 90 day(s) after the loss. All Proof of Loss should be sent to Us. However, all claims should be submitted to Us within 90 day(s) of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:
1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: Can We have a claimant examined or request an autopsy?
While a claim is pending We have the right at Our expense:
1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: When are benefit payments issued?
When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 day(s) after such Proof of Loss is received.

Claims to be Paid: To whom will benefits for my claim be paid?
Benefits for Loss of Life will be paid in accordance with the Beneficiary Designation. If no beneficiary is named, payment will be made according to the beneficiary designation under the group life policy issued to the Policyholder and in effect at the time of death.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1) the executors or administrators of Your estate; or
2) all to Your surviving Spouse; or
3) if Your Spouse does not survive You, in equal shares to Your surviving Child(ren); or
4) if no Child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Accidental Death Benefit up to $1,000 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor’s estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.
Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Accidental Death and Dismemberment Insurance Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving Spouse or the executors or administrators of Your estate.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;  
2) a person who is a minor; or
3) a person who is not legally competent,
then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

**Beneficiary Designation:** How do I designate or change my beneficiary?  
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

**Claim Denial:** What notification will my Beneficiary or I receive if a claim is denied?  
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision.

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

**Claim Appeal:** What recourse do my Beneficiary or I have if a claim is denied?  
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:
1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

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

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

**Assignment:** Are there any rights of assignment?  
Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign Your rights and interest under The Policy including, but not limited, to the following:
1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:
1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:
1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

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

**Legal Actions:** When can legal action be taken against Us?  
Legal action cannot be taken against Us:
1) sooner than 60 days after the date Proof of Loss is furnished; or
2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

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

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

**Misstatements:** *What happens if facts are misstated?*
In the absence of Insurance Fraud, if material facts about You or Your Dependents were not stated accurately:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

**DEFINITIONS**

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

**Actively at Work** means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:
1) in the usual way; and
2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Actively at Work will also include a Business Trip.

Actively at Work does not include everyday travel to and from work.

**Airworthiness Certificate** means:
1) the “Standard” Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

**Business Trip** means a bona fide trip while on assignment for or at the direction of the Employer for the purpose of furthering the business of the Policyholder which:
1) begins when You leave Your residence or place of regular employment, whichever occurs last, for the purpose of beginning the trip; and
2) ends when You return to Your residence or place of regular employment, whichever occurs first.

**Civil or Public Aircraft** means a civil or public aircraft which:
1) has a current and valid Airworthiness Certificate;
2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
3) is not operated by the militia, or armed forces of any state, national government or international authority.

**Common Carrier** means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

**Contributory Coverage** means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.
Dependent Child(ren) means:
Your unmarried children, newborn child, stepchildren, legally adopted children, child in the process of adoption from the moment of placement; or any other children related to You by blood or marriage or domestic partnership; provided such children are primarily dependent upon You for financial support and maintenance and are:

1) from live birth but not yet 19 years; or
2) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability. You must submit proof, satisfactory to Us, of such children’s disability.

Newborn child includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth.

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States, its territories and protectorates. Any person who is in full-time military service cannot be a Dependent.

Earnings means Your regular annual rate of pay, not counting bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last Policy Anniversary Date.

However, if You are an hourly paid Employee, Earnings means the product of:

1) the average number of hours You worked per year, not including overtime, over the most recent 2 year period, immediately prior to the last Policy Anniversary Date, multiplied by:
2) Your hourly wage in effect on the date immediately prior to the last Policy Anniversary Date.

Employer means the Policyholder.

FAA means:
1) the Federal Aviation Administration of the United States; or
2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

Injury means bodily injury resulting:
1) directly from an accident; and
2) independently of all other causes;
which occurs while You or Your Dependents are covered under The Policy.

Loss resulting from:
1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;
is not considered as resulting from Injury.

Military Transport Aircraft means a transport aircraft operated by:
1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of a governmental authority recognized by the United States.

Motor Vehicle means a self-propelled, four (4) or more wheeled:
1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;
not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

On means, when used with reference to any conveyance (land, water or air), in or on, boarding or alighting from the conveyance.

Physician means a person who is:
1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not Related to You by blood or marriage.
Prior Policy means the group accidental death and dismemberment insurance Policy carried by the Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, grandchild, or step-child or similar relationship in law.

Spouse means Your spouse who is not legally separated or divorced from You. Spouse will include Your domestic partner or party to a civil union, provided You:
  1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners or parties to a civil union for purposes of The Policy; or
  2) have registered as domestic partners or parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.
You will continue to be considered domestic partners or parties to a civil union provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

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

We, Us, or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.
AMENDATORY RIDER

This rider is attached to all certificates given in connection with The Policy and is effective on The Policy Effective Date.

This rider is intended to amend Your certificate, as indicated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your certificate will affect Your coverage. In addition, any reference made herein to Dependent coverage will only apply if Dependent coverage is provided in Your certificate.

For Colorado residents:

1) The **Dependent Termination** provision is replaced by the following:

   **Dependent Termination: When does coverage for my Dependent end?**

   Coverage for Your Dependent will end on the earliest to occur of:
   1) the date Your coverage ends;
   2) the date the required premium is due but not paid;
   3) the date You are no longer eligible for Dependent coverage;
   4) the date We or the Employer terminate Dependent coverage;
   5) the date the Dependent no longer meets the definition of Dependent; or
   6) the date Your Spouse reaches age 70.

   unless continued in accordance with the continuation provisions.

   However, Dependent Child coverage will not terminate if the Dependent Child is enrolled in a postsecondary education institution and takes a medical leave of absence before the earlier of:
   1) one year after the first day of the Medically Necessary Leave of Absence; or
   2) the date the coverage would otherwise terminate under the terms of coverage.

   Medically Necessary Leave of Absence means a leave of absence from a postsecondary educational institution or a change in enrollment of the Dependent Child at the institution that:
   1) begins while the Dependent Child is suffering from a serious illness;
   2) is medically necessary; and
   3) causes the Dependent to lose student status for the purpose of Dependent Child coverage.

2) Item #2 of the definition of **Dependent Child(ren)** is amended to read as follows:

   any other children related to You by blood or marriage or civil union or domestic partnership who:

3) The following is added to the definition of **Spouse**:

   Spouse will include Your partner in a civil union.

4) The **Change in Family Status** provision is amended to read as follows:

   A Change in Family Status occurs when:
   1) You get married or enter a civil union or You execute a domestic partner affidavit;
   2) You or Your spouse are divorced or terminate a civil union or terminate a domestic partnership;
   3) Your child is born or You adopt or become the legal guardian of a child;
   4) Your spouse or party to a civil union or domestic partner dies;
   5) Your child is no longer financially dependent on You or dies;
   6) Your spouse or party to a civil union or domestic partner is no longer employed, which results in a loss of group insurance; or
   7) You have a change in classification from part-time to full-time or from full-time to part-time.

**Newlywed Coverage:** If You marry or enter into a civil union or You execute a domestic partner affidavit while covered under The Policy, Your Spouse or party to a civil union or domestic partner shall automatically become covered under The Policy for 31 days of the date of marriage or civil union or domestic partnership. Benefits and amounts will be the minimum amount for those We are providing for Spouse coverage under The Policy at that time.

Coverage of Your Spouse or party to a civil union or domestic partnership will cease after 31 days of the date of marriage or civil union or domestic partnership unless You:
   1) request in writing that coverage for Your Spouse or party to a civil union or domestic partner be continued; and
2) pay the additional required premium.

**Newborn/New Child Coverage:** If, while covered under The Policy, You:
1) have a newborn child; or
2) adopt or receive a foster or stepchild;
the child will become covered under The Policy for 31 days of the date of birth or the date of financial dependence on You. Benefits and amounts will be the minimum amount for those We are providing for Dependent Children under The Policy at that time.

Coverage of the new child will cease after 31 days of the date of birth or financial dependence unless You:
1) request in writing that coverage for Your child be continued; and
2) pay the additional required premium.

For Delaware residents:

The **Spouse** definition is amended to read as follows:

**Spouse** means Your spouse who is not legally separated or divorced from You.

Spouse will include Your party to a civil union, provided You:
1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

For Hawaii residents:

The **Spouse** definition is amended to read as follows:

**Spouse** means Your spouse who is not legally separated or divorced from You.

Spouse will include Your party to a civil union, provided You:
1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

For Illinois residents, The **Policy Interpretation** provision is deleted.

For Louisiana residents:
1) the following will be considered **Dependent Child(ren)** and are added to the definition of **Dependent Child(ren)**:
   a) unmarried Child who is placed in your home pursuant to an adoption placement agreement; executed with a licensed adoption agency (from the date of placement in your home);
   b) an unmarried Child who is placed in your home following execution of an act of voluntary surrender (as of the date on which the act of voluntary surrender becomes irrevocable);
   c) your unmarried grandchild who is in your legal custody.
2) The child limiting age is changed to 21 years, or 24 years if a student, if less than such ages.
3) The following is added to the definition of **Dependent Child(ren)**: "Coverage will be continued for a Child up to age 24 who is deemed to be unable to attend school full-time due to a mental or nervous condition, problem or disorder."
4) The following replaces the last sentence of the **Dependents** definition: "Any person who is in full-time military service cannot be a dependent, unless that person is subsequently called to military service and any required premium is paid."
5) The following provision is added:

**Reinstatement after Military Service:** Can my coverage be reinstated after return from active military service? If:
1) Your coverage terminates because You enter active military service; and
2) You are rehired within 12 months of the date You return from active military service; then coverage may be reinstated, provided You request such reinstatement within 31 days of the date you return to work.

The reinstated coverage will:
1) be the same coverage amounts in force on the date coverage terminated; and
2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
3) be subject to all the terms and provisions of The Policy.

For Massachusetts residents, the following is added to the Continuation Provisions:
Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:
1) 90 days from the date You were no longer eligible for coverage as a Full-time Active Employee;
2) the date You become eligible for similar benefits under another group plan;
3) the last day of the period for which required premium is made;
4) the date the group insurance policy terminates; or
5) the date Your Employer ceases to be a Participant Employer, if applicable.
Continued coverage is subject to all other applicable terms and conditions of The Policy.

For Maine residents:
1) The time period stated in the Notice of Claim provision is changed to 30 days if not already 30 days.
2) The time period stated in the Claim Forms provision is changed to 15 days if not already 15 days.
3) The time periods stated in the Sending Proof of Loss provision are changed to 90 days and 1 year if not already 90 days and 1 year, respectively.
4) The time period stated in the Claim Payment provision is changed to 30 days if not already 30 days.
5) The dollar amount stated in the Claims to be Paid provision is changed to $2,000 if not already $2,000.
6) The phrase "In the absence of Insurance Fraud" is deleted from the Misstatements provision.

For Michigan residents:
The Policy Interpretation provision is deleted in its entirety.

For Montana residents:
1) The time period stated in the Conversion Right provision is changed to 3 years, if greater than 3 years.
2) The dollar amount stated in the Conversion Right provision is changed to $10,000, if less than $10,000.
3) The 2nd paragraph of the Conversion Policy Provisions is deleted.
4) The dollar amount stated in the second paragraph of the Claims to be Paid provision is changed to $500, if not $500.
5) The following provision is added to the Claims to be Paid provision.

Payable Interest: Is interest payable on death claims?
Claims payable for loss of life will be paid within 60 days of the date due proof is received. If the claim is paid more than 30 days after the date due proof is received, the amount payable will include interest. Interest will be paid at the discount rate, on 90-day commercial paper, in effect at the Federal Reserve Bank in the Ninth Federal Reserve District on the date due proof is received.

For New Hampshire residents:
1) Item 1 of the definitions of Disabled and Disabled or Disability is replaced by the following:
   1) performing any work or occupation for wage or profit for which You are, or become, reasonably qualified by reason of education, training or experience.
2) Item 3 of the last paragraph of the Sending Proof of Loss provision is deleted.
3) Item 3 of the Conditions for Qualification provision is replaced by the following:
   1) provide such proof in accordance with the Sending Proof of Loss provision.
4) The Policy Interpretation provision is deleted.
5) The time period stated in the definition of Period of Confinement in the Accident Hospital Income Benefit, is changed to 180 days, if less than 180 days.
6) Item 1 of the definition of Extended Care Facility in the Extended Care Facility Benefit is replaced by the following:
   1) Operates pursuant to law;
7) The following is added to the Period of Coverage:

Spouse Continuation: Can coverage be continued for a divorced Spouse?
If You are legally separated or divorced from Your Spouse, coverage for Your former Spouse may continue under The Policy until the earliest of:
1) the last day of the third year following the anniversary of a final divorce or legal separation;
2) the date You remarry;
3) the date Your former Spouse remarries;
4) a date specified in the final divorce decree;
5) the date Your former Spouse fails to pay any premiums that may be due; or
6) the date You die.

For Oregon residents:
1) The Spouse definition is amended to read as follows:
   Spouse means Your spouse who:
   1) is under age 65;
   2) is not legally separated or divorced from You; and
   3) is not in active full-time military service outside the continental United States, Hawaii, Puerto Rico or Alaska. However, Your spouse who is in active full-time military service inside the continental United States, Hawaii, Puerto Rico or Alaska will be considered a Dependent.

   Spouse will include Your domestic partner provided You:
   1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
   2) have registered as domestic partners with a government agency or office where such registration is available.

   You will continue to be considered domestic partners provided You continue to meet the requirements of the law or as described in the domestic partner affidavit.

2) The following is added to the definition of Dependent Child(ren):
   Dependent Child(ren) will also include child(ren) of Your Oregon registered domestic partner.

3) The Continuation Provisions section is amended to include the following for Employers with 10 or more employees:
   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your employer in accordance with Your employer’s notification policy.

For Rhode Island residents:
1) The Spouse definition is amended to read as follows:
   Spouse means Your spouse who is not legally separated or divorced from You.

   Spouse will include Your party to a civil union, provided You:
   1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
   2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

   You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

2) The following is added to Continuation Provisions:
   Family Military Leave of Absence: If Your spouse or child enters active full-time military service outside of the continental United States, Hawaii, Puerto Rico or Alaska, and You:
   1) have been employed with the same employer for at least two years; and
   2) have completed 1,250 hours of service during a 12 month period immediately prior to the date Military Leave of Absence would begin; and
   3) have exhausted all the other time made available to You by Your Employer except sick time and short term disability;
   then Your coverage may be continued for up to 30 days. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

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

For South Carolina residents:
1) The time period in the Notice of Claim provision is changed to 20 days, if not already 20 days.
2) The following is added to the Physical Examinations and Autopsy provision: “Such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.”
3) Item 2 of the Legal Actions provision is replaced by the following:
   2) 6 years of the date Proof of Loss is required to be furnished according to the terms of The Policy.

For South Dakota residents, the provision titled Policy Interpretation is deleted in its entirety.
For Texas residents, the provision titled Policy Interpretation is deleted in its entirety.

For Utah residents:
1) The following benefits are not available:
   - Anti-Inflation Benefit
   - Therapeutic Counseling Benefit
   - Accidental Death Benefit with Double Indemnity while On a Common Carrier
   - Accidental Death Motor Vehicle Benefit
   - Accidental Death Benefit while in a Covered Accident
   - Accidental Death and Dismemberment: while Actively at Work
   - Double Indemnity while On A Common Carrier

2) The maximum age for a student, stated in the Child Education Benefit is changed to 26 if not already 26.

3) The definition of Dependent Child(ren) is amended as follows:
   1) items a and b of item 2 are deleted
   2) the second item 2 is deleted
   3) the maximum age for a child is changed to 26 if not already 26.

4) The following is added to the first sentence of the Change in Family Status provision:
   or from the date of placement for adoption with You.

5) Item 3 of the Sending Proof of Loss provision is deleted in its entirety.

6) The age references in the Continuation for Dependent Child(ren) with Disabilities provision are changed to 26 if not already 26.

7) Waiting periods must be eliminated from all Accidental Death and Dismemberment policies, including the Accidental Hospital Income Benefit.

For Vermont residents:

**Purpose:** Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

**Definitions, Terms, Conditions and Provisions:** The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

1) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.

2) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

3) Terms that mean or refer to family relationships arising from a marriage, such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

4) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

**CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE**

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have
access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

For Washington residents:
1) The Accelerated Benefit is not available.
2) The provision titled Policy Interpretation is deleted in its entirety.

For Wisconsin residents:
The time periods stated in the Claim Appeal provision are removed.

In all other respects, the Policy and certificates remain the same.

Signed for Hartford Life and Accident Insurance Company.

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

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

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

1. **Plan Name**
   
   Group Accidental Death and Dismemberment Plan for employees of Associated Colleges of the Midwest - Carleton College.

2. **Plan Number**
   
   501

3. **Employer/Plan Sponsor**
   
   Associated Colleges of the Midwest - Carleton College
   1N College Street, Room 109
   Northfield, MN 55057

4. **Employer Tax Identification Number**
   
   41-0694747

5. **Type of Plan**
   
   Welfare Benefit Plan providing Accidental Death and Dismemberment benefits.

6. **Plan Administrator**
   
   Associated Colleges of the Midwest - Carleton College
   1N College Street, Room 109
   Northfield, MN 55057
   507-222-4068

7. **Agent for Service of Legal Process**
8. **Sources of Contributions**  
The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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

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

11. **Labor Organizations**

    International Union of Operating Engineers  
    Local 70 AFL - CIO, 2417 Larpenteur Ave West  
    Saint Paul, MN 0

12. **Names and Addresses of Trustees**

    None

13. **Plan Amendment Procedure**

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

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

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

1. Receive Information About Your Plan and Benefits

   a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

   c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.
Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

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

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

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

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

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

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

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

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.
However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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