YOUR BENEFIT PLAN

Nidec Americas Holding Corporation
Kato Union (IBEW)

Accidental Loss of Life and Severe Injury Benefits / Accidental Death and Dismemberment

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State Notices

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

The insurance carrier for the Policy is:

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

The Claims Administrator for the Policy is:

The Hartford
Group Life Claims
P.O. Box 14299
Lexington, KY 40512-4299
1-888-563-1124

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

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

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

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

NOTICES

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

Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

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

  For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance.
- Illinois:
  You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

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

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

  Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
  Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431
- Texas: In addition to the insurance coverage, We may offer Noninsurance Benefits and Services to You. Your access to these benefits and services is included with Your insurance coverage and does not require enrollment or premium payment. You should contact the Policyholder for more information on the services available on their plan.

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

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

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

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

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

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

Have a complaint or need help?

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

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

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

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

Teléfono gratuito: 1-800-523-2233

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

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

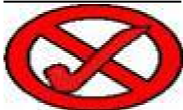
Llame con sus preguntas al: 1-800-252-3439

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

- Wisconsin: **For Your Questions and Complaints:**
  To request a Complaint Form:
  Office of the Commissioner of Insurance
  Complaints Department
  P.O. Box 7873
  Madison, WI 53707-7873
  1(800) 236-8517 (within Wisconsin)
  1(608) 266-0103 (outside of Wisconsin)
- Virginia: **For Your Questions and Complaints:**
  State Corporation Commission
  Life and Health Division
  Bureau of Insurance
  P.O. Box 1157
  Richmond, VA 23218
  1(804) 371-9691 (inside Virginia)
  1(877) 310-6560 (outside Virginia)

CERTIFICATE FACE PAGE

- Colorado: THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.
- Idaho: **This is an Accident-only Certificate and it does not pay benefits for loss for sickness. Review Your Certificate carefully.**
- Massachusetts:



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

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

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

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

- New Hampshire: This is a Limited Policy - Read it Carefully
- New Hampshire: **This policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.**

BENEFIT SCHEDULE

- Maine: We will pay a minimum amount of $2,000 for covered losses due to accidental death or two or more dismemberments, if not already shown as an amount of $2,000 or more in the Benefit Schedule.
- New Hampshire: We will pay a minimum amount of $1,000 for covered losses for one digit, $2,500 for covered losses for single dismemberments and $5,000 for two or more dismemberments, if not already shown as these amounts or more in the Benefit Schedule.
- Texas: The Non-Insurance Services paragraph is removed and replaced with the Noninsurance Benefits and Services notice in the Notices section above.

DEFINITIONS

- South Dakota: The definitions of **Chiropractor, Dentist, Medical Professional, Physician,** and **Therapist**

include Family Members if they are the only qualified provider of such service in the area and acting within the scope of their practice.

- South Dakota: The hourly time requirement, described in the **Confined, Confinement** definition, does not apply to Your coverage.
- Idaho: The disabled child section of the Dependent Child(ren) definition is revised to specify that proof of disability will not be required more than once annually after the initial claim is submitted.
- Minnesota, Montana: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 25 unless shown as higher, provided Dependent Coverage is available under the Policy.
- New Hampshire, Utah: The Dependent Child limiting age, described in the **Dependent Child(ren)** definition, is up to age 26, if not already shown as 26 and provided Dependent Child coverage is available under the Policy.
- New Hampshire: The unmarried Dependent Child requirement, described in the **Dependent Child(ren)** definition, does not apply, provided Dependent Child coverage is available under the Policy.
- New Hampshire, Utah: The student extension if shown in the **Dependent Child(ren)** definition does not apply, provided Dependent Child coverage is available under the Policy.
- Utah: The disability extension in the **Dependent Child(ren)** definition is amended to require that the Dependent Child have a medically determinable physical impairment provided Dependent Child coverage is available under the Policy. In addition, proof of such impairment will only be required to be submitted annually after an initial 2 year period from the time the child has reached the limiting age.
- Montana: The definition of **Medical Professional** is revised to include the following list of practitioners: Physician, Dentist, osteopath, Chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist, speech-language pathologist, audiologist, and licensed addiction counselor.
- Oregon: The definition of **Spouse** is amended to include domestic partner coverage; if not already shown and to state the following: "Residents of Oregon in same-sex domestic partnerships are not required to demonstrate or prove their relationship through documentation or other requirements that are not also required for legal marriages."
- Vermont: Provided Dependent Spouse coverage is available the definition of **Spouse** is amended to include domestic partnerships and civil unions, if not already included in the **Definitions** section of the Certificate.
- Montana: You have full freedom of choice in the selection of any health care provider for Treatment of an Accident within the health care provider's scope and limitations of practice, including: licensed physician; physician assistant; Dentist; osteopath; Chiropractor; optometrist; podiatrist; psychologist; licensed social worker; licensed professional counselor; licensed marriage and family therapist; acupuncturist; naturopathic physician; physical therapist; speech language pathologist, audiologist, licensed addiction counselor or advanced practice registered nurse.

ELIGIBILITY AND EFFECTIVE DATES

- Utah: The **New Dependent Coverage** provision is amended to clarify that the date of acquisition is the date of birth for any newborn child placed with You for adoption within 30 days of birth.

REINSTATEMENT OF COVERAGE

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

CONTINUATION AND EXTENSION OF COVERAGE

- New Hampshire: The following **Extension of Coverage While Disabled** provision is added to the **Continuation and Extension of Coverage** section:
  Extension of Coverage While Disabled
  If You are Disabled when coverage would otherwise terminate because:
    1) You are no longer eligible for insurance or are no longer in an Eligible Class; or
    2) the Policy terminated;
  coverage will be extended for 90 days after it would otherwise terminate, while Disability continues.
- Rhode Island: The following continuation option applies to Your coverage, if not already included in the **Continuation Option(s)** provision in the Certificate:
  Federal or State Laws: The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or

state laws, may allow continuation of insurance in certain circumstances for medical leaves of absence, military leaves of absence, other leaves of absence, layoff or termination of employment.

BENEFITS

- Tennessee: The **Felonious Assault Benefit** or **Workplace Felonious Assault Benefit** is revised to remove the exclusion for family members and members of the Covered Person's household, if shown and if either benefit is included under the Policy.
- Alaska, Hawaii: The **Carjacking Benefit** and **Felonious Assault Benefit** or **Workplace Felonious Assault Benefit** are revised to remove the exclusions for family members and members of the Covered Person's household, if shown and if either benefit is included under the Policy.
- Washington: The loss period from date of Accident for Accidental Death and Dismemberment benefits in the **Benefits** section of the Certificate is updated to show as 365 days unless shown as higher in your Certificate.

GENERAL LIMITATIONS & EXCLUSIONS

- Alaska: The extreme sports and activities exclusion, if included in the **Exclusions** provision, is limited to the listed sports and activities listed in the exclusion.
- Idaho, Nevada, South Dakota: The voluntary intoxication and voluntary intoxication through use of poison, gas or fumes exclusions, if included in the **Exclusions** provision, does not apply to Your coverage.
- Idaho: The following additional exclusions, if included in the **Exclusions** provision, do not apply to Your coverage: voluntary participation in illegal activities, voluntary engagement in an illegal occupation, incarceration or imprisonment, travel in or descent from any vehicle or device for aviation or aerial navigation, acrobatic tricks or stunts in an aircraft or motor vehicle, participation in an organized sport in a semi-professional capacity, extreme sports or activities, auto-erotic asphyxiation, use of illegal fireworks and cellular/distracted driving.
- Missouri: The suicide exclusion, if included in the **Exclusions** provision, is not applicable to suicide committed while the insured person is insane.
- New Hampshire: The felony, incarceration, extreme sports and activities, Seat belt, use of illegal fireworks, auto-erotic asphyxiation and cellular/distracted driving exclusions, if included in the **Exclusions** provision do not apply to Your coverage.
- New Jersey: The voluntary intoxication exclusion, if included in the **Exclusions** provision, is not applicable to being under the influence of a drug or controlled substance.
- New Jersey: Participation in a Riot, if cited in the **Exclusions** provision, is not applicable to Your coverage.

CLAIM PROVISIONS

- Colorado: The **Claim Appeal** provision includes the following:
  If a claim for benefits has been denied in whole or in part and all administrative remedies have been exhausted, the claimant is entitled to have the claim reviewed de novo (from the beginning) in any court with jurisdiction and to a trial by jury.
- New Hampshire: The one year time limitation to provide proof of loss if unable to provide within the initial proof of loss period, as described in the **Proof of Loss** provision, does not apply to You.
- North Carolina: The initial proof of loss period, described in the **Proof of Loss** provision, is 180 days.
- Minnesota, North Carolina: The payment period, described in the **Time of Payment of Claims** provision, is immediately upon Our receipt of due Proof of Loss.

GENERAL PROVISIONS

- Alaska: The **Statements** provision is not applicable to statements made with the intent to defraud.
- New Hampshire, North Carolina: The **Time Limit on Certain Defenses** provision is not applicable to statements made with the intent to defraud.
- Alaska, Idaho, Illinois, Kansas (for Policies not subject to ERISA only), Rhode Island, South Dakota, Texas, Vermont: The **Policy Interpretation** provision, if shown, is not applicable to Your coverage.

GROUP ACCIDENT INSURANCE CERTIFICATE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

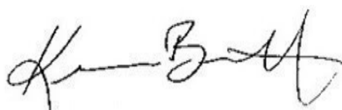
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see www.thehartford.com.

Policyholder: Nidec Americas Holding Corporation
Policy Number: ADD-S09439
Policy Effective Date: January 1, 2026
Policy Anniversary: January 1

We have issued the Policy to the Policyholder. The Policy is delivered in and governed by the laws of the state of Missouri, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy that are important to the Covered Person(s) are summarized in this Certificate, consisting of this form and any additional forms which have been made a part of this Certificate. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy on file with Us at Our Home Office. The current version of the Certificate for each Eligible Class included in the Policy replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. The Policy may be inspected at the office of the Policyholder.

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



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

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

Notice to Buyer: Accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a covered Accident, subject to any limitations contained in the Policy. Coverage is NOT provided for basic hospital, basic medical-surgical or major medical expenses. Review Your Certificate carefully.

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

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

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

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

READ THIS CERTIFICATE CAREFULLY. The Primary Insured has a 30-day right from their Coverage Effective Date to examine this Certificate. If the Primary Insured is not satisfied, it may be returned to Us within 30 days from receipt of this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.

A note on capitalization in this Certificate:

Capitalization of a term not normally capitalized according to the rules of standard punctuation indicates a word or phrase that is a defined term in the Policy or refers to a specific provision contained herein.

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BENEFIT SCHEDULE

Eligible Class(es)
All Full-time Active Employees who are members of the International Brotherhood of Electrical Workers working in Kato who are subject to a collective bargaining agreement

Coverage Type
24 hour – This Certificate provides coverage for Accidents that occur at any time, whether an Employee is working or during their free time, subject to all of the applicable requirements, maximums, limitations, Definitions, Exclusions and other provisions of the Policy.

Coverage Election
In order to be insured under the Policy an Employee must elect coverage for themself.

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

Supplemental Coverage Amount(s)*
- **Employee**: $5,000

*Coverage Amount(s) will be frozen at time of electing Extended Continuation.

Any Coverage Amount for an Employee will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000.

In the event of any questions regarding the Coverage Amount for any Covered Person, please contact the Policyholder. All Coverage Amount(s) are Guaranteed Issue.

BENEFIT(S) TABLE

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

All **Benefit Amounts** are a percentage of the applicable Coverage Amount(s) in effect for a Covered Person at the time of a covered Accident, unless otherwise stated as a specific dollar amount or as a percentage of other benefits payable.

Benefit:	Benefit Amount:
DEATH BENEFIT(S)	
Death	
Basic Death	100%
Dismemberment/Functional Loss	
Basic Dismemberment/Functional Loss	
Thumb and Index Finger	25%
One Hand or One Foot	50%
One Arm or One Leg	50%
Loss of Sight of One Eye	50%
Catastrophic Dismemberment/Functional Loss	
One Hand and One Foot	100%
Both Hands or Both Feet	100%
One Arm and One Leg	100%
Both Arms or Both Legs	100%
Loss of Sight of Both Eyes	100%
Loss of Hearing of Both Ears	50%
Loss of Speech	50%
Paralysis	
One Limb (Monoplegia or Uniplegia)	25%

Benefit:	Benefit Amount:
Two Limbs (Diplegia, Hemiplegia or Paraplegia)	50%
Three Limbs (Triplegia)	75%
Four Limbs (Quadriplegia)	100%
Coma	5% per month

ENHANCEMENT BENEFIT(S)

Seat Belt • *Benefit Maximum* • *Benefit Minimum*	10% *$10,000* *$1,000*
Air Bag	$5,000

RECOVERY BENEFIT(S)

Bereavement Counseling	$100 per day

DEFINITIONS

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

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

Actively at Work, Active Work means that an Employee is:
1) performing all the regular duties of their job for the Policyholder in the usual way for 30 or more hours each week; and
2) receiving compensation from the Policyholder for work performed.

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

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

Air Bag means a manufacturer installed, inflatable, supplemental restraint device in a Motor Vehicle, or proper replacement restraints installed to the vehicle manufacturer’s specifications, that:
1) meets published federal safety standards; and
2) inflates upon collision to help protect a person from Injury.

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

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

Change in Family Status means one of the following events:
1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
2) You and Your Spouse divorce or legally terminate Your relationship;
3) Your Spouse dies;
4) You acquire a child who satisfies the definition of Dependent Child;
5) Your child no longer satisfies the definition of a Dependent Child or dies;
6) Your Spouse is no longer employed, which results in a loss of insurance sponsored by the Spouse’s employer for You; or
7) You change work classification from part-time to full-time or from full-time to part-time.

Coma or Comatose means a profound stupor or state of complete and total unconsciousness with no reaction to external stimuli or response to internal needs, that is diagnosed by a Physician with a Glasgow Coma Scale score of 8 or less (or equivalent), for which intubation is required for respiratory assistance. A coma does not include a medically induced coma or a coma that is the result of any alcohol or drug use.

Common Carrier means a method of common public transport with defined published routes, time schedules and rates approved by regulators. A common carrier includes public airlines, railroads, subways, trolleys, boats and bus lines. A common carrier does not include taxis, limousines, any privately chartered mode of transportation or any mode of transportation owned, operated or leased for or by the Policyholder.

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

Covered Injury means an Injury that is the direct result of an Accident that is not excluded or limited by any other provision of the Policy. If a Covered Person is unavoidably exposed to the elements of nature as the result of an Accident that results in one or more Injuries or Illness, such Injuries and Illness that are a direct result of the exposure will be deemed to be covered injuries that have occurred as the result of the Accident.

Covered Person means the Employee who is currently insured under the Policy and this Certificate.

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

who is/are:
1) unmarried; and
2) under 26 years of age.

If an unmarried child is age 26 or older and is:
1) incapable of self-sustaining employment because of a mental or physical disability;
2) chiefly dependent on the Employee or Spouse for financial support and maintenance;

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

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

This definition does not include a person working for the Policyholder:
1) on a temporary, leased or seasonal basis;
2) as an independent contractor (including persons for whom income is reported on a 1099 form);
3) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
4) who resides outside the United States for a period in excess of 12 months, unless Written approval has been received from Us.

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

Functional Loss means any of the following:
1) Loss of Hearing – Permanent loss of hearing in an ear with an aided hearing loss range of 71 decibels (dB HL) or higher (unable to hear sound at or below 70 dB HL) that cannot be improved or corrected to any greater functional degree by any aid, procedure or device.
2) Loss of Sight – Permanent loss of sight in an eye with no realistic expectation of improvement, or severance of an eye. With best correction of an eye, visual acuity must be 20/200 or worse or the field of vision must be less than 20 degrees.
3) Loss of Speech – Total and permanent loss of audible voice communication that cannot be corrected to any functional degree by any aid, procedure or device.

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

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

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

Hospital does not include:
1) convalescent homes, or convalescent, rest or nursing facilities;

2) facilities affording primarily custodial care; or
3) facilities primarily for care of the aged/elderly, care of persons with Substance Use Disorders, or care of persons with mental health disorders.

Illness means:
1) a physical disease, disorder, illness or infirmity (including medical or surgical Treatment thereof);
2) a mental health disorder or Substance Use Disorder;
3) pregnancy or childbirth; and
4) infection, except for infection that is the natural result of a Covered Injury.

Injury or Injuries means bodily damage or harm that must be independent of Illness or any other cause and requires Treatment by a Physician or Medical Professional.

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

Motor Vehicle means any vehicle with two to four wheels powered by an internal combustion engine and/or electric motor that is appropriately registered for use on public roadways, including:
1) automobiles (cars, trucks, vans or sport utility vehicles (SUVs));
2) motorcycles or low-power cycles (scooters or mopeds); or
3) recreational vehicles (RVs), motor homes or campers, which include living quarters designed for accommodation.

This definition does not include farm equipment; all-terrain vehicles; recreational off-highway vehicles (ROVs, including "side-by-sides" and utility task vehicles (UTVs)); off-road motorcycles; or any vehicle that is being used in a Common Carrier capacity or to carry passengers for a fee.

Paralysis means the total, permanent and irreversible loss of use of one or more limbs without severance.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling of their own authority with intent to mutually assist one another in an illegal or legal act. For purposes of this definition, a riot includes an insurrection or rebellion.

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

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

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

Prior Policy means any similar accident insurance policy or plan:
1) replaced by insurance under part or all of the Policy; and
2) in effect and maintained or sponsored by:
   a) the Policyholder on the day before the Policy Effective Date; or
   b) an employer acquired by the Policyholder at any time after the Policy Effective Date.

Seat Belt means:
1) a manufacturer installed lap and/or shoulder restraint, or proper replacement restraints installed to the vehicle manufacturer's specifications, that meets published federal safety standards; or
2) a child restraint device that meets current National Safety Council standards and is installed according to manufacturer recommendations for children of like age and weight.

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

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

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

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

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

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

ELIGIBILITY & EFFECTIVE DATES

Eligibility for Coverage
An Employee will become eligible for coverage under the Policy on the later of:
1) the Policy Effective Date; or
2) the date they become a member of an Eligible Class.

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

Initial Enrollment
An Employee must enroll for coverage for the Employee within 31 days following the day the Employee first become(s) eligible for coverage under the Policy.

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

Coverage Effective Date
Coverage will start on the latest to occur of:
1) the date an Employee becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
2) the Policy Anniversary following the last day of an Annual Enrollment Period, if an Employee is enrolled during an Annual Enrollment Period;
3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee is enrolled during an Additional Enrollment Event; or
4) the date an Employee is enrolled for coverage that requires an enrollment.

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

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

This provision does not apply to Employees who are currently eligible for coverage under the Continuity from a Prior Policy provision.

Continuity from a Prior Policy
Coverage under the Policy will begin and will not be deferred if, on the day before the Policy Effective Date, an Employee:
1) was insured under a Prior Policy; and
2) is otherwise eligible under the Policy but is not Actively at Work on the Policy Effective Date and:
   a) is on a leave of absence protected under:
      i. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA); or
      ii. any other applicable federal or state law that allows for continuation of insurance in certain instances; or
   b) was eligible for and insured under a continuation provision of a Prior Policy on the day before the Policy Effective Date;

provided the Employee is not insured under any continuation (including any waiver of premium for total disability), portability or conversion provision of a Prior Policy after the Policy Effective Date.

Coverage under this provision is subject to the following additional conditions:

1) the Coverage Amount for any Employee under the Policy may not exceed the amount of insurance in effect under the Prior Policy on the day before the Policy Effective Date;
2) the Policyholder must notify Us in Writing prior to the Policy Effective Date of the Coverage Amount for any Employee under the Prior Policy on the day before the Policy Effective Date; and
3) insurance under this provision is subject to uninterrupted payment of premium to Us when due.

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Coverage provided through this provision ends on the first to occur of:
1) the last day of the 12th month on or next following the Policy Effective Date;
2) the last day the Employee would have been covered under the Prior Policy, had the Prior Policy not terminated;
3) the last day of the continuation period allowed by FMLA, USERRA or applicable federal or state law;
4) the date insurance terminates for any reason shown under the Termination of Coverage provision; or
5) the date the Employee resumes Active Work for the Policyholder or begins full-time employment with any other employer.

If an Employee is eligible for insurance under this provision, the Employee is not eligible for insurance under any Continuation or Extension of Coverage provision of this Certificate. Except as stated in this provision, coverage under this provision is subject to all other terms and provisions of the Policy.

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

Any change in coverage requested by an Employee will become effective on:
1) the Policy Anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
2) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
3) the date on which the change is requested following a Change in Family Status;

subject to the Deferred Coverage Effective Date provision.

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

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

New Dependent Coverage
If You:
1) marry; or
2) acquire a child who satisfies the definition of Dependent Child(ren);

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

If Dependent coverage requires an election under the Policy, You must enroll the Dependent for coverage subject to the Changes in Coverage provision in order for the Dependent to remain insured beyond the initial 31 day period. You will have a minimum of 10 days from Your receipt of requested enrollment materials to enroll a Dependent Child for coverage.

TERMINATION OF COVERAGE

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

When coverage would otherwise end, You may be able to continue insurance:
1) under a Continuation provision;
2) under the Extension of Coverage provision; or
3) under the Extended Continuation provision.

Termination of coverage has no effect on benefits payable for an Accident or a Covered Injury that occurred while a Covered Person was insured under the Policy.

CONTINUATION & EXTENSION OF COVERAGE

CONTINUATION

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

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:
1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf); and
2) the Policyholder must approve the continuation.

Coverage continued under this provision will end on the earliest of the day:
1) the applicable continuation time period has expired, as described in the Continuation Option(s);
2) You return to Active Work for the Policyholder; or
3) You begin full-time employment with an employer other than the Policyholder.

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

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

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

EXTENSION OF COVERAGE

Extension of Coverage While Confined
If You are Confined to a Hospital for a period of 30 consecutive days or more as a result of an Accident for which a benefit for Confinement is payable or was previously paid under the Policy, coverage under the Policy may continue without payment of premium for all Covered Persons for the duration of Your Confinement.

Any premium for insurance under this Certificate will be waived from the first day of the month following the date the Confinement begins through the last day of the month in which the Confinement ends.

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

EXTENDED CONTINUATION

Extended Continuation

You may continue coverage under the Policy when insurance would otherwise end under the Termination of Coverage provision.

You may be able to continue coverage under this provision when You:
1) are no longer Actively at Work and are not eligible for coverage under any other Continuation or Extension of Coverage provision in this Certificate; or
2) are no longer employed by the Policyholder, including retirement.

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

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

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

Coverage continued under this provision will end on the earliest of:
1) the last day of the month during which You resume Active Work for the Policyholder;
2) the last day of the month on or next following the date that is 5 years from the date continuation under this provision began.

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

BENEFITS

All benefits are subject to all the applicable requirements, maximums, Definitions, Exclusions and other provisions of the Policy. The Benefit Amounts shown in the Benefit Schedule may be adjusted or reduced based on other benefits payable or previously paid under the Policy, as described in the following provisions. Please read all sections of the Certificate carefully in order to fully understand each benefit.

Benefits are only payable for an Accident that occurs while a Covered Person is insured under the Policy. We will not pay benefits for an Accident that occurred prior to a Covered Person’s effective date of coverage under the Policy.

DEATH BENEFIT(S)

The total benefit amount payable for any Covered Person for an Accident in the Death category will not exceed the highest applicable benefit amount, unless otherwise indicated within any Death Benefits provision. If We pay a benefit and subsequently an additional loss is sustained by a Covered Person for which a higher benefit is payable as a result of the same Accident, We will pay any difference in the two amounts as an additional benefit amount.

DEATH

Basic Death Benefit
We will pay the Basic Death Benefit Amount shown in the Benefit Schedule if a Covered Person dies as the result of one or more Covered Injuries sustained in an Accident.

The death must occur within 365 days after the Accident and be independent of all other causes.

Exposure and Disappearance
If a Covered Person is unavoidably exposed to the elements of nature as the direct result of an Accident and as a result of such exposure dies, the Covered Person will be presumed to have died, for the purpose of any death benefit, as the result of the Accident.

A Covered Person will be presumed to have died, for the purpose of any death benefit:

1) if the Covered Person disappears and the disappearance:
    a) is caused solely and directly by an Accident that could reasonably have caused death; and
    b) is independent of all other causes; and
2) the Covered Person's body is not found within 1 year from the date of disappearance (unless otherwise required or allowed by applicable law) despite reasonable search efforts; and
3) a valid death certificate is issued for the Covered Person by a court of appropriate jurisdiction.

PARALYSIS

Paralysis Benefit
We will pay the applicable Paralysis Benefit Amount shown in the Benefit Schedule if a Covered Person sustains one or more Covered Injuries that result in Paralysis.

The Paralysis must be diagnosed by a Physician within 365 days after the Accident and be independent of all other causes. This benefit is only payable once per Accident for each Covered Person.

COMA

Coma Benefit
We will pay the Coma Benefit Amount shown in the Benefit Schedule for each month a Covered Person is in a Coma for 30 or more consecutive days as the result of one or more Covered Injuries.

The Covered Person must become Comatose within 30 days after the Accident.

Once the minimum Coma duration is satisfied, the monthly benefit is payable for each month during which the Covered Person became or remains Comatose, until the earliest to occur of:

1) the end of the month in which the Covered Person recovers from the Coma;
2) the end of the month in which the Covered Person dies;
3) the total benefits paid under the Policy for this Coma Benefit and any Paralysis benefits paid for the same Accident reach the applicable Basic Death Benefit Amount for the Covered Person; or
4) a total of 20 monthly payments have been made.

ENHANCEMENT BENEFIT(S)

Seat Belt Benefit
We will pay an increased benefit if a Covered Person dies or sustains one or more of the following Covered Injuries:

1) Paralysis; and
2) Coma;

as the result of an Accident that occurred while the Covered Person was operating or riding in a Motor Vehicle while wearing a properly fastened Seat Belt. This benefit increases the total benefits payable for an Accident for death and the specified Covered Injuries by the percentage shown in the Benefits Schedule, up to the Seat Belt Benefit Maximum.

A copy of the police report for the Accident documenting proper Seat Belt usage by a Covered Person must be submitted with the claim.

If it cannot be determined that the Covered Person was wearing a Seat Belt at the time of the Motor Vehicle Accident, the Seat Belt Minimum Benefit shown in the Benefit Schedule is the maximum benefit amount payable for this benefit.

This benefit will not be paid for a Covered Person if at the time of the Accident:

1) the Covered Person was breaking any laws of the jurisdiction in which the Accident occurred; or
2) a Seat Belt was used to restrain more than one person at the time of the Accident, including the Covered Person.

Air Bag Benefit
If the Seat Belt Benefit is payable for a Motor Vehicle Accident for a Covered Person under the Policy, We will also pay the Air Bag Benefit Amount shown in the Benefit Schedule if at the time of the Motor Vehicle Accident the Covered Person was:

1) positioned in a seat equipped with an Air Bag; and
2) wearing a properly fastened Seat Belt when the Air Bag inflated.

A copy of the police report for the Accident documenting:
1) proper Seat Belt usage by a Covered Person;
2) the positioning of the Covered Person; and
3) the deployment of an Air Bag;

must be submitted with the claim.

This benefit is payable in addition to any other benefits payable under the Policy.

RECOVERY BENEFIT(S)

Bereavement Counseling Benefit
We will pay the Bereavement Counseling Benefit Amount shown in the Benefit Schedule for each day a Covered Person or one or more of Your Spouse and Dependent Child(ren), if not covered under the Policy, receives bereavement counseling from a licensed counselor, psychologist, or psychiatrist following the death of a Covered Person as the result of an Accident for which a death benefit is payable/was paid under the Policy.

The counseling must begin within 90 days from the date of the death. All counseling must be rendered within 365 days from the date of death. This benefit is payable for up to 10 day(s) per Accident for each Covered Person or Dependent that receives counseling, and is only payable once per day.

This benefit is payable in addition to any other benefits payable under the Policy.

EXCLUSIONS

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

Exclusions
No benefits are payable under the Policy for any Accident, Injury or loss that results from, is caused by, is contributed to by or occurs during a Covered Person's:
1) suicide or attempted suicide, while sane, or intentional self-infliction;
2) voluntary intoxication (as defined by the law of the jurisdiction in which the Injury or loss occurred) or while under the influence of any narcotic, drug or controlled substance unless administered by or taken according to the instruction of a Physician or Medical Professional;
3) voluntary intoxication through use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;
4) voluntary commission of or attempt to commit a felony, voluntary participation in illegal activities (except for misdemeanor violations), voluntary Participation in a Riot, or voluntary engagement in an illegal occupation;
5) incarceration or imprisonment following conviction for a crime;
6) travel in or descent from any vehicle or device for aviation or aerial navigation, except:
   a) as a fare-paying passenger in a commercial aircraft (other than a charter airline) that flies at a level no higher than the Earth's stratosphere on a regularly scheduled passenger flight; or
   b) while traveling on business of the Policyholder;
7) travel in or descent from any vehicle or device for aviation or aerial navigation:
   a) as a pilot, student pilot or crewmember;
   b) as a flight instructor or examiner;
   c) owned, operated or leased by or on behalf of the Policyholder or any employer or organization whose employees or members are covered under the Policy;
8) riding in or on any motor vehicle or aircraft engaged in acrobatic tricks/stunts (for motor vehicles), acrobatic/stunt flying (for aircraft), endurance tests, off-road activities (for motor vehicles), or racing;
9) participation in any organized sport in a professional or semi-professional capacity for which the Covered Person receives remuneration or payment;
10) participation in abseiling, base jumping, Bossaball, bouldering, bungee jumping, cave diving, cliff jumping, free climbing, freediving, freerunning, hang gliding, ice climbing, Jai Alai, jet powered flight, kite surfing, kiteboarding, luging, missed climbing, mountain biking, mountain boarding, mountain climbing, mountaineering, parachuting, paragliding, parakiting, paramotoring, parasailing, Parkour, proximity flying, rock climbing, sail gliding,

sandboarding, scuba diving, sepak takraw, slacklining, ski jumping, skydiving, sky surfing, speed flying, speed riding, train surfing, tricking, wingsuit flying, or other similar extreme sports or high risk activities;
11) active duty service or training in the military (naval force, air force or National Guard/Reserves or equivalent) for service/training extending beyond 31 days of any state, country or international organization, unless specifically allowed by a provision of this Certificate;
12) involvement in any declared or undeclared war or act of war (not including acts of terrorism), while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer, unless War Risk Coverage is specifically allowed through a current War Risk Rider of the Policy; or
13) use of illegal fireworks (as defined by the law of the jurisdiction in which the Injury or loss occurred) or the use of any legal fireworks when not following the manufacturer's lighting instructions.

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

Please consult the Policyholder for information regarding any War Risk Coverage available through a current War Risk Rider of the Policy.

In addition, We will not pay for any benefits under the Policy, unless required by law, for:
1) medical mishap or negligence on the part of any acupuncturist, chiropractor, therapist, Physician or Medical Professional, including malpractice;
2) Treatment, supplies or services provided by, through or on behalf of any government agency or program, unless payment is required by a Covered Person;
3) elective or cosmetic surgery or procedures classified by the treating Physician to be elective or cosmetic, except for reconstructive surgery incidental to or following surgery for trauma of the involved body part; and
4) dental care or Treatment, except for Treatment due to an Injury to sound natural teeth within 12 months of the Accident.

CLAIM PROVISIONS

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

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

Claim Forms
When We receive Notice of Claim, We will send claim forms. If the claimant does not receive the forms within 15 days after Notice of Claim is sent, Proof of Loss may be sent to Us without waiting to receive the claim forms. The claimant shall be deemed to have complied with the requirements for Proof of Loss if the Written proof covering the occurrence, character, and extent of the loss for which claim is made is submitted within the timeframe allowed for Proof of Loss.

Proof of Loss
The claimant must send proof of loss to Us. This proof must be provided within 90 days after the date of the loss. Failure to furnish proof will not invalidate nor reduce any claim if it is not reasonably possible to give proof in this time and proof is provided as soon as reasonably possible. However, proof of loss may not be given more than one year after the date:
1) of an Accident;
2) of service or Treatment for any Covered Injury; or
3) an expense or service is incurred as the result of an Accident;

for which benefits are sought unless the claimant is legally incapacitated.

For any benefits payable on a monthly basis We may request subsequent proof of loss throughout the ongoing period, as reasonably required. If requested, We must receive the proof within 30 days of the request unless the claimant is legally incapacitated.

Physical Examinations and Autopsy
We, at Our own expense, shall have the right and opportunity to have:
1) a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and

2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims
Benefits payable under the Policy, other than any benefit(s) payable on a monthly basis, will be paid within 30 days after Our receipt of due Proof of Loss. Any benefit(s) payable on a monthly basis:

1) are payable not less frequently than monthly and within 30 days after Our receipt of due Proof of Loss as described in the applicable benefit provision;
2) may, at Our option, be paid in advance based on Our estimated duration of monthly benefits payable; and
3) will be paid as soon as possible after Our receipt of due Proof of Loss, if unpaid at the termination of the monthly benefit period.

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

1) Your Spouse;
2) Your children;
3) any individual who is a partner to You in a civil union or domestic partnership, or other relationship as recognized and allowed by applicable law in Your jurisdiction of residence;
4) Your parents;
5) Your siblings; or
6) Your estate.

Beneficiary Designation
In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

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

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

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable. In no event may a Power of Attorney change a beneficiary designation, unless legally granted by You or Your assignee (if you absolutely assigned this insurance).

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

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

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

1) must submit a Written request for review within:
    a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of an Accident or other loss; or

   b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of an Accident or other loss; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit Written comments, documents, records and other information relating to the claim.

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

Overpayment Recovery
We have the right to recover from You or the recipient of benefits any amount that We determine to be an overpayment, within 12 months from the date the claim was paid. You or the recipient of benefits has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:
1) refer the unpaid balance to a collection agency; and
2) pursue and enforce all legal and equitable rights in court.

GENERAL PROVISIONS

Entire Contract
This insurance is provided under a contract of group insurance with the Policyholder. The entire contract between the Policyholder and Us includes the following:
1) the Policy, which includes the Certificate(s) for each Eligible Class of the Policy;
2) the Policyholder's signed application (if any); and
3) any riders, amendments or endorsements to the Policy.

Statements
All statements made by the Policyholder or any Covered Person are considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person, their beneficiary or personal representative.

Time Limit on Certain Defenses
No statement concerning insurability made by any Covered Person shall be used to contest the validity of the insurance for which the statement was made after this Policy has been in force for two years. In order to be used, the statement must be in Writing and signed by the person making the statement. However, We are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this Policy, or upon other provisions in the Policy.

Legal Actions
No legal action may start:
1) until 60 days after Proof of Loss has been given; or
2) more than 3 years after the time Proof of Loss is required to be given, unless otherwise required by law in Your or the claimant's jurisdiction of residence.

Misstatement of Age
If the age of any Covered Person has been misstated the true facts will be used to determine:
1) if, and for what amount, coverage should have been in force; and
2) if the Covered Person is eligible for any benefit that includes age-based requirements.

Assignment
You have the right to absolutely assign Your rights and interest under the Policy including, but not limited to, the following:
1) the right to make any contributions required to keep the insurance in force; and
2) the right to name and change a beneficiary.

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

We and the Policyholder assume no responsibility:

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

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

Insurance Fraud
Insurance fraud occurs when any person or the Policyholder provides 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 a person or the Policyholder commits 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 a person or the Policyholder perpetrate insurance fraud.

Conformity with State and Federal Laws
Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

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

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

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

APPENDIX ONE
NOTICE OF PROTECTION PROVIDED BY
MISSOURI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

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

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Missouri law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are as follows:

• Life Insurance

• $300,000 in death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values

• Health Insurance

• $500,000 for health benefit plans

• $300,000 in disability insurance benefits

• $300,000 in long-term care insurance benefits

• $100,000 in other types of health insurance benefits

• Annuities

• $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. The maximum amount of protection for each individual, regardless of the number of policies or contracts, is as follows:

• $300,000 in aggregate for all types of coverage listed above, with the exception health benefit plans

• $500,000 in aggregate for health benefit plans

(please turn to next page)

• $5,000,000 to one policy owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons

"Health benefit plan" is defined in section 376.718, RSMo.

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

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the basic life insurance policy or annuity contract to which it relates.

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

Missouri Life and Health
Insurance Guaranty Association
630 Bolivar Street, Suite 204
Jefferson City, Missouri 65101
Ph.: 573-634-8455
Fax: 573-634-8488

Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101
Ph.: 573-522-6115

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

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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

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

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

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1. **Plan Name**

   For employees of Nidec Americas Holding Corporation:

   Group Accidental Death and Dismemberment Plan

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2. **Plan Number**

   Group Accidental Death and Dismemberment - 501

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3. **Employer/Plan Sponsor**

   NIDEC AMERICAS HOLDING CORPORATION
   8050 W FLORISSANT AVE
   SAINT LOUIS, MO 63136

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4. **Employer Identification Number**

   27-3330722

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5. **Type of Plan**

   Welfare Benefit Plan providing:

   Group Accidental Death and Dismemberment Insurance.

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6. **Plan Administrator**

   NIDEC AMERICAS HOLDING CORPORATION
   8050 W FLORISSANT AVE
   SAINT LOUIS, MO 63136

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

For the Plan

NIDEC AMERICAS HOLDING CORPORATION

8050 W FLORISSANT AVE
SAINT LOUIS, MO 63136

For the Policy:

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

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

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8. **Sources of Contributions**

   (Group Accidental Death and Dismemberment) Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

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

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

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

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

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

Claims for Benefits

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

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

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

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

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

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

Claim Procedures for Claims Not Requiring a Determination of Disability

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

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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