YOUR
BENEFIT
PLAN

Alabama First Responder Benefits Association

Maryland

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

State Notices

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

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

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

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

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

Alaska:

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

Arizona:

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

Arkansas:

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

California:

1. **NOTICE:** You and Your Dependent(s) must be insured with major medical insurance in order to be eligible under the Policy.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, does not apply to You. The following requirement applies to You:

   Eligibility Determination:
   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine the Covered Person's eligibility for benefits for any claim the Covered

Person or the Covered Person's estate make on the Policy. We will:

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

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

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

Colorado:

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

Connecticut:

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

Florida:

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

Georgia:

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

Idaho:

1. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The continuously insured time period, as shown in the **Pre-existing Condition Limitation** of the **Limitations and Exclusions** section**,** is 6 consecutive months; unless if shown as less.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the Limitations and Exclusions section, is 6 consecutive months; unless if shown as less.

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

Illinois:

1. **For Your Questions and Complaints:**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
   Web Address: http://insurance.illinois.gov/
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. In accordance with Illinois law, insurers are required to provide the following NOTICE to applicants of insurance policies issued in Illinois.

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

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

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

Indiana:

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

Kansas:

1. The following requirement applies to You:

   Policy Interpretation:
   Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to US the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all

terms and provisions of the Policy. Therefore, We are a fiduciary for the Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under the Policy. This provision only applies where the interpretation of the Policy is governed by ERISA.

Louisiana:

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

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

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

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

Maine:

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

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

Michigan:

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

Montana:

1. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months, unless if shown as less.
2. Benefits and coverage amounts for a newborn or newly adopted child will be equal to the benefits and coverage amounts offered under the Policy for Dependent Child(ren), as shown in the **Benefit Schedule**.
3. Coverage for a newly adopted child, as described in the **Eligibility and Enrollment** section, will cease immediately if placement is disrupted or the child no longer is in the custody of You or Your Spouse.

New Hampshire:

1. The **Waiting Period**, located in the **Benefit Schedule**, is 30 days; unless if shown as less.
2. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Limitations and Exclusions** section, is 6 consecutive months; unless if shown as less.
3. **Proof of Loss,** as shown in the **Claim Provisions** section, must be provided within 90 days of the date of loss.
4. Part-time employees who work at least 15 hours per week are eligible for coverage.
5. A Dependent will no longer meet the definition of **Dependent Child** upon attainment of age 26.
6. Spouse coverage may be continued under the Policy even after divorce or separation. Coverage may be continued to a maximum of 3 years or earlier if ordered by a divorce decree. The continuation will cease if the Primary Insured dies or the former Spouse remarries.

7. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.

New Jersey:

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

New Mexico:

1. Coverage terminates at age 26 for Dependent Child(ren) who are not handicapped or disabled.
2. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.
3. **NOTICE: This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

New York:

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

North Carolina:

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

Oregon:

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

Rhode Island:

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

South Dakota:

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

Texas:

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

   To obtain information or make a complaint:

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

   1-800-523-2233

   You may also write to The Hartford at:

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

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

   1-800-252-3439

   You may write the Texas Department of Insurance:

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

   PREMIUM OR CLAIM DISPUTES:

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

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

   AVISO IMPORTANTE

   Para obtener información o para presentar una queja:

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

   1-800-523-2233

   Usted también puede escribir a The Hartford:

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

   Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

   1-800-252-3439

   Usted puede escribir al Departamento de Seguros de Texas a:

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

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

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

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

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

Virginia:
1. The definition of **Spouse** only includes anyone who is recognized as a spouse under Virginia state law.
2. Domestic partners and other relationships allowable by Virginia state law are eligible for Dependent coverage; if Dependent coverage is available under the Policy.
3. **For Your Questions and Complaints:**
   Life and Health Division
   Bureau of Insurance

P.O. Box 1157
Richmond, VA 23209
1(804) 371-9741 (inside Virginia)
1(800) 552-7945 (outside Virginia)

Wisconsin:

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

FIREFIGHTER CANCER INSURANCE CERTIFICATE – PLAN 1

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

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

Policyholder: Alabama First Responder Benefits Association Inc., DBA Alabama First Responder Benefits Program
Policy Number: 681675
Policy Effective Date: January 1, 2020
Policy Anniversary Date: January 1
Department's Effective Date: See applicable Application/Agreement

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

Signed for Hartford Life and Accident Insurance Company

Lisa Levin, *Secretary*

Jonathan Bennett, *President*

This is a limited certificate. It pays benefits only for specific losses from Cancer. Read it carefully.

For questions or complaints, please contact Us at 1-800-461-9326.

This Certificate provides limited or supplemental coverage. It pays benefits ONLY upon the occurrence and Diagnosis of a Specified Disease. This Certificate does not provide benefits for any other disease, sickness or incapacity. Benefits provided are supplemental and are not intended to substitute for medical coverage or disability insurance.

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

NOTICE: The benefits of the policy providing You coverage do not reflect all the rights and benefits to which

You are entitled to per ACT2019-316.

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) for Coverage: All Eligible Firefighters

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

Coverage Amount: $25,000

Lifetime Benefit Maximum: $50,000

Critical Illness Benefits

Critical Illness:	**Percentage of Coverage Amount:**
Invasive Cancer	100%
Non-Invasive Cancer	25%
Benign Brain Tumor	100%

Recurrence Benefit:	**Percentage of Coverage Amount:**
Invasive Cancer	100%
Benign Brain Tumor	100%

Additional Benefit:	**Benefit Amount:**
Non-Invasive Skin Cancer	$250 once per lifetime

DEFINITIONS

Active Firefighter means an Eligible Firefighter whose primary duties are the prevention and extinguishing of fires; the protection of life and property; and the enforcement of municipal, county and state fire prevention codes and laws pertaining to the prevention and control of fires.

Benign Brain Tumor means a condition Diagnosed as a non-malignant tumor or cyst in the brain, cranial nerves or meninges within the skull with a minimum size of 1 cm, resulting in either surgical removal or permanent neurological deficit with persisting clinical symptoms. The Diagnosis must be made by a Physician who is board certified in the medical specialty that is appropriate for the type of tumor involved. The tumor, including its size, should be documented on an MRI of the brain (with and without contrast) or by pathological diagnosis. If the Covered Person is unable to undergo an MRI of the brain (the study is deemed inappropriate for safety reasons such as the presence of metallic foreign bodies; mechanical reasons such as body habitus; or unavailability), then the tumor should be documented by a CT scan of the head, with and without contrast. Benign Brain Tumor does not include tumors in the pituitary gland or angiomas.

Cancer means a disease caused by an uncontrolled division of abnormal cells in a part of the body or a malignant growth or tumor resulting from the division of abnormal cells. For purposes of this Policy, this definition includes Benign Brain Tumor.

Career Firefighter means any person employed with the state, a county or municipal government, an airport authority, or a fire district who has obtained certification as a firefighter through and as defined by the Alabama Firefighters' Personnel Standards and Education Commission; or a firefighter employed by the Alabama Forestry Commission who has been certified by the State Forester as having met the wild land firefighter training standard of the National Wildfire Coordinating Group, and is offered typical employment benefits, including health insurance coverage.

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

Certified Volunteer Firefighter means any person who is an active member of a volunteer or combination career and volunteer fire department, as recognized by the Alabama Forestry Commission, and who has obtained certification as a volunteer firefighter through and as defined by the Alabama Firefighters' Personnel Standards and Education Commission, who may or may not receive remuneration for firefighting activities, but is not offered typical employment benefits, including health insurance coverage.

Covered Person means an Eligible Firefighter who is currently insured under the Policy and this Certificate.

Diagnosed, Diagnosis means the definitive establishment of a Cancer through the use of clinical or laboratory findings. The diagnosis must be made by a Physician who is a board certified specialist where required in the Policy. Any type of medically appropriate diagnosis will be accepted. For a pathological diagnosis, the date of diagnosis for Cancer is the date the tissue specimen, blood samples or titer(s) are taken upon which the diagnosis of Cancer is based.

Eligible Firefighter means a Career Firefighter, Certified Volunteer Firefighter or Non-Certified Volunteer Firefighter who has been employed by his or her Department for at least 12 consecutive months.

Department means any Paid Fire Department or Volunteer Fire Department.

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

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

Invasive Cancer means Diagnosis of Cancer involving any malignant tumor or neoplasm characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue. The term malignant tumor includes leukemia, lymphoma and sarcoma. Malignant melanoma or other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis (the outer layer of skin) with a Clark's level III or greater, Breslow's depth of .75mm or greater, or AJCC TNM stage II or greater, are included in this definition.

The Diagnosis must be made by a Physician who is board certified in the medical specialty that is appropriate for the type of cancer involved.

Conditions which are not considered invasive cancer are not included in this definition. Such conditions include, but are not limited to:

1) any condition defined as Non-Invasive Cancer;
2) all cancers which are histologically classified as pre-malignant, non-invasive/carcinoma in situ, having borderline malignancy or having low malignant potential;
3) benign tumors or polyps;
4) early prostate cancer that is histologically classified as T1N0M0 or equivalent staging;
5) chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A; and
6) any condition defined as Non-Invasive Skin Cancer

Non-Invasive Cancer means a Diagnosis of Cancer in which the tumor or cells still lie within the tissue of origin without having invaded neighboring tissue or regional lymph nodes. Non-invasive cancer includes, but is not limited to:

1) early prostate cancer that is histologically classified as AJCC TNM Stage T1N0M0 or equivalent staging;
2) chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A;
3) cutaneous lymphoma; and
4) any condition defined as Non-Invasive Skin Cancer

The Diagnosis must be made by a Physician who is board certified in the medical specialty that is appropriate for the type of cancer involved.

Pre-malignant lesions (intraepithelial neoplasia, for example), and benign tumors or polyps are not included in this definition.

Non-Invasive Skin Cancer means a Diagnosis of skin Cancer (melanoma or non-melanoma) that has not invaded the reticular (lower) dermis that is histologically classified as:

1) Clark Level I or II;

2) Breslow Thickness of less than .75mm; or
3) AJCC TNM Stage 0 or I.

Non-Certified Volunteer Firefighter means any person who is an active member of a volunteer or combination career and volunteer fire department, as recognized by the Alabama Forestry Commission, and who has not obtained certification as a volunteer firefighter through and as defined by the Alabama Firefighters' Personnel Standards and Education Commission, who may or may not receive remuneration for firefighting activities, but is not eligible for typical employment benefits, including health insurance coverage.

Paid Fire Department means any department or division of the state, a county or municipal government, an airport authority, or a fire district with paid employees assigned firefighting duties.

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing arts acting within the scope of his/her license; and
2) not the Covered Person or a Family Member.

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

Volunteer Fire Department means a group of area residents organized to provide fire protection and recognized by the Alabama Forestry Commission as a volunteer fire department.

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

You or **Your** refers to the Covered Person.

ELIGIBILITY AND EFFECTIVE DATE

Eligibility for Coverage:
An Eligible Firefighter will become eligible for coverage on the later of:

1) the current Department's Effective Date; or
2) the date the firefighter satisfies the definition of Eligible Firefighter.

Coverage Effective Date:
Coverage will start on the day the Eligible Firefighter becomes eligible.

Enrollment:
To enroll You must:

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

TERMINATION OF INSURANCE

Termination of Coverage:
Coverage will end on the earliest of the following:

1) the last day of the month during which You are no longer an Eligible Firefighter with any Department;
2) the date the required premium is due but not paid;
3) the date that all Departments for whom You are active as an Eligible Firefighter cease to participate in the Policy; or
4) the date the Policy terminates;

unless continued in accordance with one of the Extended Continuation provision.

Termination of coverage has no effect on benefits payable for a Cancer that is Diagnosed while You were insured

under the Policy.

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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 are no longer active as a Firefighter, provided You have been covered under the Policy for at least one year.

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

The request and the initial premium due must be received within 91 days after insurance under the Policy would otherwise end. 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.

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, including any portion of the premium that was previously paid for by the Your Department.

Coverage continued under this provision will end on the last day of the month during which You are again active as a Firefighter and become eligible for coverage under the Policy as a result of active Firefighter status. 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.

CANCER BENEFITS

If You are Diagnosed with Cancer while covered under the Policy, We will pay the applicable Benefit Amount shown in the Benefit Schedule.

Each benefit shown in the Benefit Schedule will be paid once for each Covered Person, unless a Recurrence Benefit is available. Following the payment of any benefit at 100% of the Coverage Amount, a period of 30 days must be satisfied before payment of any other benefit under the Policy. Following the payment of any benefit at 25% of the Coverage Amount, there is no period of time to be satisfied before payment of any other benefit.

In no event will the total benefits paid under the Policy or this Certificate for any Diagnosis of Cancer exceed the Cancer Lifetime Benefit Maximum shown in the Benefit Schedule, even if a Covered Person has coverage under the Policy from more than one Department.

Recurrence Benefit:
We will pay a Recurrence Benefit as shown in the Benefit Schedule if a Covered Person receives a Diagnosis of a recurrence of a Critical Illness previously paid under the Policy. For a Recurrence Benefit to be paid:
1) the condition must be listed as a Recurrence Benefit in the Benefit Schedule; and
2) the Diagnosis of recurrence must be made 90 days or more following the initial Critical Illness Diagnosis for that same condition.

In no event will the total Critical Illness Benefits or Recurrence Benefits paid under the Policy or this Certificate, or under any similar policy or certificate issued to another legally organized fire department in the state of Alabama, exceed the Lifetime Benefit Maximum shown in the Benefit Schedule.

CLAIM PROVISIONS

Notice of Claim:
Written Notice of Claim must be given to Us within 30 days of a loss covered by this Certificate, or as soon as is reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

Claim Forms:
When We receive written Notice of Claim, We will send claim forms. If We do not furnish claim forms with 15 days after We receive notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to Proof of Loss by submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Loss:
The claimant must send written proof of loss to Us. This proof must be provided within one year of the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. If We require additional information in order to make a claim determination, We shall provide written notice to the claimant. The additional information must be provided within 45 days from the date of the request.

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 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 this Certificate will be paid immediately after Our receipt of due written Proof of Loss.

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

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, Department, plan administrator or the office/system where beneficiary records for the Policy are kept.

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, Department, 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, Department, 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.

Claim Denial:
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of

why it is necessary;
4) provide an explanation of the review procedure; and
5) include contact information for the Florida Office of Insurance Regulation.

Claim Appeal:
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so he or she:
1) must request a review upon written application within 60 days of receipt of claim denial;
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 make a final decision no more than 45 days after We receive Your timely appeal. The time for a final decision may be extended for one additional 45 day period by notifying You in writing that an extension is necessary due to special circumstances, identifying those circumstances and providing You the date We expect to have a final decision on the claim.

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

GENERAL PROVISIONS

Statements:
In the absence of fraud, all statements made by the Policyholder or any Covered Person will be considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or personal representative. No statement made by a Covered Person shall avoid the insurance or reduce benefits unless contained in a written instrument signed by such Covered Person.

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

Legal Actions:
No legal action may start:
1) until 60 days after proof of loss has been given;
2) more than 6 years after the time proof of loss is required to be given.

Policy Interpretation:
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

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

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

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

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hartford Life Insurance Company and Hartford Life and Accident Insurance Company (collectively "The Hartford" or "we") are committed to protecting the privacy of your health information. The Hartford is required by a federal law - the Health Insurance Portability and Accountability Act (HIPAA) - to take reasonable steps to ensure the privacy of your "Protected Health Information" (PHI) and to provide you with this Notice of Privacy Practices. PHI includes all individually identifiable health information transmitted or maintained by The Hartford and/or its business associates regardless of form (oral, written, electronic).

This Notice applies to PHI obtained through the following coverages only: Senior Medical Insurance Plan, Group Retiree Insurance Plan and Medicare Supplement for Employer Groups, Tricare/CHAMPUS, Prescription Drug coverage, Association Medicare Supplement, Medical Conversion, Long-Term Care and other Medical Products only.

Effective Date: This Notice was originally effective April 14, 2003 and as revised is effective September 23, 2016.

Uses and Disclosures of Your PHI

This section of the Notice explains how The Hartford uses and discloses your PHI with our employees, business associates, and other organizations as required or permitted by law without your authorization. We also require our business associates to protect the privacy of your PHI through written agreements with The Hartford. As explained below, we will request your written authorization in some instances to use or disclose PHI. In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI as described herein, we will restrict our uses and disclosures of PHI in accordance with this more restrictive law.

Required Disclosures. The use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate and/or determine The Hartford's compliance with HIPAA's privacy regulations.

Uses and Disclosures Related to Treatment, Payment and Healthcare Operations. The Hartford and/or its business associates may use and disclose PHI without your authorization or opportunity to agree or object for activities related to treatment, payment, and healthcare operations. In these instances, The Hartford will not request your authorization to share PHI. As described in the next section titled **Your Privacy Rights**, you have the right to request a restriction on the use and disclosure of your PHI for treatment, payment, or healthcare operations purposes. The Hartford may not use any PHI that is "genetic information" (as defined by the Genetic Information Nondiscrimination Act of 2008) for underwriting purposes. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities.

Examples of activities related to treatment include: treatment provided by a specialist who asks a primary care physician to share a patient's PHI.

Examples of activities related to payment include: payment of healthcare claims, determinations whether a member is eligible for healthcare coverage, or collection of premiums.

Examples of activities related to healthcare operations include: quality improvement; fraud and abuse prevention and detection; case management and medical review; underwriting; and complaint resolution.

Uses and Disclosures of Your PHI That Do Not Require Your Authorization or Opportunity to Object. Your PHI may be disclosed without your authorization in the following circumstances: when required by law; public health activities; instances involving victims of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, as required or permitted by law; governmental health oversight activities (including audits, investigations, and inspections); judicial and administrative proceedings; certain law enforcement purposes; deceased persons to coroners, health examiners, and funeral directors; organ and tissue donation; certain government-approved research purposes; upon reasonable belief to avert a serious threat to health or safety; specialized government functions (such as military personnel, and inmates in correctional facilities); to individuals involved in your care or payment for your care; emergency treatment situations; disaster relief; or workers' compensation.

Use and Disclosures to Plan Sponsor. In some circumstances, The Hartford may also disclose PHI to the sponsor of your group health plan for plan administration functions.

Use and Disclosure to Contact You Regarding Health-Related Benefits and Services. The Hartford or its business associates may also contact you regarding health-related benefits and services that may be of interest to you.

Uses and Disclosures That Require Your Written Authorization. In all other circumstances not described above, uses and disclosures of your PHI will only be made with your written authorization. For example, we will need your authorization for the following circumstances:

- most uses or disclosures of psychotherapy notes;
- marketing communications; and
- disclosures that constitute a sale of PHI.

You may revoke such an authorization at any time, except to the extent The Hartford, its business associates, or other entities have relied on such disclosure.

Your Privacy Rights

This section of the Notice describes your rights as an individual with respect to your PHI and a brief description of how you may exercise these rights.

Right to Restrict Uses and Disclosures for Treatment, Payment and Healthcare Operations Purposes. You have the right to request that we restrict uses and disclosure of your PHI for activities related to treatment, payment and healthcare operations as described above. Your request for the restriction must be in writing. We will evaluate all requests for restrictions, however, we are generally not required to agree to the restriction. In certain circumstances, we may be obligated to honor your request for a restriction on disclosures to another health plan relating to a health care item or service for which you paid in full. If we agree to the restriction, we will abide by it, except in the case of emergency treatment or when required by law. We will terminate our agreement to a restriction if you agree to or request the termination of the restriction. If we decide to terminate our agreement to the restriction, we will notify you of our decision.

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

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

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

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

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

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

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

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

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

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

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

We will provide you with one free accounting each year. For subsequent requests, we will charge a reasonable fee.

The written accounting of disclosures will include the following information for each disclosure: the date of the disclosure, the person to whom the information was disclosed, a brief description of the information disclosed or in lieu of the summary, a copy of the written request for the disclosure.

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

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

Complaints. You may file a complaint with The Hartford or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with The Hartford, contact the Corporate Privacy Office at CorporatePrivacyOffice@thehartford.com. We will not retaliate against you for filing a complaint. If you have any questions about this Notice, or the subjects addressed in it including how to exercise your rights as set forth in this Notice, please contact the Corporate Privacy Office at the email address above or call us at: 860-547-5000.

The Hartford's Duties

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

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