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

will pay benefits according to the conditions of this Policy.
Signed for the Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

NOTICE TO BUYER: This Policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

This is not a standardized Medicare Supplement Plan.

Policyholder Name: County of Fresno

Policy Number: AGP-3229

Policyholder Address: 2200 Tulare Street, Suite 1400
Fresno, CA 93721

Policy Effective Date: January 1, 2011

Policy Renewal Date: January 1/1/17 – 12/31/17

RENEWABILITY: Except for material misrepresentation, coverage under the Policy will continue by timely payment of premium until the first to occur of:

a) the date the Policy is cancelled; or
b) the date the Insured Person ceases to qualify within a class of persons eligible for coverage under the Policy.

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(All sections may not be required)

Accepted by

Policyholder

Countersigned by

Licensed Resident Agent

Form SRP-1270 A-B-1 (3229)
Printed in U.S.A.

SCHEDULE – ELIGIBILITY

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THE POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY.

Eligible Person: Eligible Persons are described below. Class 1 is eligible for Insured Person and Dependent's Coverage. Class 2 persons are not eligible for Insured Person Coverage, but may enroll their Eligible Dependents for Dependent's Coverage.

Class	Description of Eligible Persons
1	All Retired Employees of the Policyholder who are entitled to Medicare.
3	All widow/widowers of a deceased spouse who was an active or retired employee of the Policyholder.

Eligible Dependents: Eligible Persons may apply for Dependent's Coverage. Eligible Dependents are described below (if applicable to this Policy).

Description of Eligible Spouse

The Eligible Person's Spouse who is entitled to Medicare, provided the spouse is not legally separated or divorced from the Person.

Eligibility Restrictions: The Eligible Person must enroll for coverage under either this Policy or the Related Policy in order to enroll for Dependent's Coverage.

If a husband and wife are both Eligible Persons, only one may apply for Insured Person Coverage with the other covered as a Dependent only. A Spouse's Senior Medical Insurance Plan Benefit must be the same as the Eligible Person's. However, this will not apply if the Eligible Person is covered by the Related Policy.

In no event will a person be eligible for coverage under this Policy if he or she:

a) is engaged in active employment or is the Spouse of a person engaged in active employment, and is covered by an employer's health plan which is primary payor to Medicare; or
b) is covered by Medicaid; or
c) has another Senior Medical Insurance policy or certificate in force; or
d) is not covered by Medicare.

Enrollment Period: Each Eligible Retired Employee must enroll for coverage under the Policy during an enrollment period.

The initial enrollment period begins on the Policy Effective Date and ends on the 60th consecutive day following the Policy Effective Date.

Persons who become eligible for coverage after the enrollment period must enroll for coverage during the 60 consecutive days following the date they first become Eligible Persons.

We may establish later periods of open enrollment by mutual agreement with the Policyholder.

SCHEDULE - BENEFITS AND AMOUNTS

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THE POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY. (* ALWAYS INCLUDED)

Benefits and Amounts: A Covered Person's plan will be the one plan that the Eligible Person elected from the Schedule as shown below and on the following page(s). The election must be in accordance with the Eligibility provisions and all other terms of the Policy.

Senior Medical Insurance Plan Benefits

BENEFIT	**AMOUNT PAYABLE**
Hospital Confinement Benefit	
Day of Confinement	
1st to 60th Day	Medicare Part A Deductible
61st to 90th Day *	Daily Coinsurance Charge (25% of Part A Deductible per day)
Lifetime Reserve Period	Daily Coinsurance Charge (50% of Part A Deductible per day)
After Lifetime Reserve Period	100% of Hospital Expenses for each Day of Confinement for an additional 365 days of Confinement per lifetime
Skilled Nursing Facility Benefit	
Day of Confinement	
21st to 100th Day	Daily Coinsurance Charge (12 1/2% of Part A Deductible per day)

Senior Medical Insurance Plan Benefits

BENEFIT	**AMOUNT PAYABLE**
Medicare Part B Deductible Benefit Eligible Expenses	Medicare Part B Deductible
Medical Care Benefit *	20% of Medicare Eligible Expenses after the Medicare Part B Deductible
Medicare Part B Excess Charges Benefit	100% of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.

Additional Senior Medical Insurance Plan Benefits

BENEFIT	**AMOUNT PAYABLE**
Foreign Travel Emergency Medical Treatment Benefit	80% of the Foreign Travel Emergency Medical Treatment Benefit Deductible amount: $250 Lifetime Maximum Benefit Amount: $50,000

Additional Senior Medical Insurance Plan Benefits

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THE POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY. (* ALWAYS INCLUDED)

Hospice Care Benefit *	Medicare coinsurance charges for prescription drugs and inpatient respite care
Blood Deductible Benefit *	First 3 pints of blood under Medicare Part A and Medicare Part B

STATE MANDATED BENEFITS

The following Benefits are added to the Policy and Certificate. With respect to residents of:

California:	Cervical Cancer Screenings Benefit Mammography Benefit	See Benefit
Colorado:	Mammography Benefit Prostate Cancer Screening Benefit	See Benefits
Connecticut:	Home Health Aide Services Benefit Mammography Screening Benefit	See Benefits
Delaware:	Scalp Hair Prosthesis Inherited metabolic diseases Low protein modified formula or food products Medical formula or food	See Benefits See Benefits
Washington, D.C.:	Cancer Screening Benefit	See Benefit
Hawaii:	Mental Health and Alcohol and Drug Abuse Treatment Benefits	See Benefits
Iowa:	Mammography Benefit	See Benefit
Maine:	Mammography Coverage Benefit Alcoholism and Drug Dependency Benefit Mental and Nervous Disorder Benefit	 See Benefits

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STATE MANDATED BENEFITS (Continued)

The following Benefits are added to the Policy and Certificate. With respect to residents of:

Massachusetts:	Confinement for Treatment of Alcoholism Benefit Confinement for Treatment of Mental and Nervous Disorders Benefit Outpatient Treatment of Alcoholism Benefit Outpatient Treatment of Mental and Nervous Disorders Benefit Mammography Screening Benefit Cytologic Screening Benefit Enteral Formulas Benefit	See Benefits
Montana:	Mammography Screening Benefit	See Benefit
New Jersey:	Prostate Cancer Screening Benefit At Home Recovery Benefit Preventive Medical Care Benefit Mammography Coverage Benefit Wilm's Tumor Benefit	See Benefits
Pennsylvania:	Phenylketonuria Treatment Benefit	See Benefit
Rhode Island:	At Home Recovery Benefit	See Benefit
South Dakota:	Mammography Benefit Phenylketonuria Treatment Benefit	See Benefits
Texas:	Mammography Screening Benefit	See Benefit
Virginia:	Pap Smear Benefit Mammography Coverage Benefit	See Benefits

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THE POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

The following Benefits are added to the Policy and Certificate. With respect to residents of:

Wisconsin:	Mental and Nervous Disorders, Alcoholism and Drug Abuse Benefit	
	Chiropractic Services Benefit	
	Equipment and Supplies for Diabetes Treatment Benefit	
	Kidney Disease Treatment Benefit	
	Non-Medicare Approved Skilled Nursing Facility Benefit	See Benefits

SCHEDULE - PREMIUMS

Individual Premiums: Premiums for each Covered Person are stated below.

The premiums stated in this section are for monthly periods of coverage. Semi-annual premiums are 6 times and annual premiums are 12 times those stated. If a premium becomes due for a different period of time, it will be determined pro rata.

Individual Senior Medical Insurance Plan Monthly Premiums

$239.95*

*A $13.95 per person per month administrative fee for services which include but are not limited to billing, enrollment, claims payment and customer service is included in the per person per month premium.

Covered Person Premium Due Dates: The first premium for each Covered Person is due on the date he or she becomes covered under the Policy. Each Premium after the initial premium is due at the end of the period for which his or her preceding premium was paid.

Grace Period: After the initial premium, a grace period of 31 days from the Covered Person Premium Due Date is allowed each Insured Person for payment of each premium due after his or her initial premium. A Covered Person's coverage will be continued during the grace period. If he or she Incurs a covered loss during the grace period, the Insured Person will be liable to us for payment of any premium accruing during the period we continued coverage in force under this provision. The grace period will not continue coverage beyond a date stated in a Termination provision.

Policy Premium: The premium for this Policy is the sum of Individual Premiums for each Covered Person.

Policy Premium Due Dates: The Policy Premium is payable on:

a) the Policy Effective Date; and
b) the 1st day of each month thereafter, with respect to each Covered Person whose premium becomes due on such date, subject to the Individual Grace Period provision.

Each Policy Premium is due on or in advance of the date it becomes payable. The Policy terminates on the last day of the period for which premium is paid.

SCHEDULE - PREMIUMS (Continued)

Policy Premium Payment: The Policy Premiums are to be paid to us by the Policyholder. However, they may be paid to us by any other person according to a mutual agreement among the other person, the Policyholder and us.

Change of Policy Premiums: We have the right on any Premium Due Date to change the rate at which future premiums will be calculated. This includes the right to change premium rates for a benefit that applies to all individuals of the same class and geographic location.

Rates may be changed based on:

a) changes in Medicare;
b) the claims experience of this Policy;
c) state or federal legislation affecting Senior Medical Insurance Policies; or
d) the experience of all groups on which we write Senior Medical Insurance Plan Benefits

We will give the Policyholder advance written notice of any change in premium rates at least 30 days (in New Jersey and New Mexico 60 days) prior to the Premium Due Date on which the change is to become effective.

Policyholder Grace Period Provision: A grace period of 31 days is allowed for payment of each premium due after the first unless the Policy is cancelled on or before the due date. The Policy will continue in force during the grace period. The Policyholder is liable to us for the payment of premium accruing for the period the Policy continues in force.

CONTRACT PROVISIONS

Entire Contract: The entire contract between the Policyholder and us consists of this Policy and any forms made a part of this Policy at issue.

All statements made by the Policyholder or the Covered Person will be deemed representations and not warranties. No statement made to effect this insurance will:

a) void the insurance; or
b) reduce benefits unless it is in writing and signed by the Policyholder or the Insured Person.

Changes: We reserve the right to make changes in the Policy. We will give the Policyholder 30 days advance written notice of any change.

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of our officers and made a part of this Policy.

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

Certificates: We will give individual Certificates to:

a) the Policyholder; or
b) any other person according to a mutual agreement among the other person, the Policyholder and us;

for delivery to Insured Persons.

The Certificates will state the features of this Policy which are important to Insured Persons.

30 Day Right to Examine Certificate: The Insured Person has a 30 day right to examine his or her Certificate. If the Insured Person is not satisfied, he or she may return it to us within 30 days of the date of its delivery. In that event, we will consider it void from the Certificate effective date and any premium paid will be refunded to either the Policyholder or Insured Person. Any claims paid will be deducted from the refund.

Data Furnished by Policyholder: The Policyholder, or any other person designated by the Policyholder, may keep the important insurance records on all Covered Persons. The Policyholder or its designee must give us information, when and in the manner we ask, to administer the insurance provided by this Policy.

The Policyholder or designee will, upon our request, give us:

a) the names of all persons initially eligible;
b) the name of all additional persons who become eligible;
c) the names of all persons whose benefit is to be changed;
d) the names of all persons whose insurance is cancelled; and
e) any data necessary to calculate premiums.

The Policyholder's failure to report a person's termination of insurance does not continue the coverage beyond the date of termination.

The Policyholder's insurance records will be open for our inspection at any reasonable time.

Clerical Error: Clerical error (whether by the Policyholder, the Plan Administrator, or us) in keeping the records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

Policy Cancellation: This Policy may be cancelled at any time by written notice mailed or delivered by us to the Policyholder or by the Policyholder to us. If we cancel, we will mail or deliver the notice to the Policyholder at its last address shown in our records.

If we cancel, it becomes effective on the later of:

a) the date stated in the notice; or
b) the 31st day after we mail or deliver the notice.

If the Policyholder cancels, it becomes effective on the later of:

a) the date we receive the notice;
b) the date stated in the notice; or
c) the 31st day after the notice is delivered or mailed.

In either event:

a) we will promptly return any unearned premium paid; or
b) the Policyholder will promptly pay any earned premium which has not been paid.

Any earned or unearned premium will be determined on a pro rata basis.

Cancellation will be without prejudice to any claim which originated prior to the effective date of the cancellation.

Not in Lieu of Worker's Compensation: This Policy does not satisfy any requirement for worker's compensation insurance.

Conformity with Law: If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

GENERAL DEFINITIONS

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Age means a Covered Person's attained age on any premium due date.

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Confined or Confinement means being an Inpatient in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

due to Sickness or Injury.

Covered Person means an Eligible Person or Eligible Dependent while covered under the Policy.

Day of Confinement means a day of Inpatient Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

for which a daily room and board charge is made for a full Day of Confinement.

Hospice Care means Medicare approved medical and support services needed to manage symptoms and relieve the pain of a terminal illness. The services must be provided through a Medicare approved Hospice Care Program. Hospice Care includes but is not limited to:

a) nursing care, therapies, medical supplies and appliances;
b) short-term Inpatient respite care; and
c) Physician, home health aide and counseling services.

Hospital means an institution which:

a) is approved by Medicare;
b) operates pursuant to law;
c) primarily and continuously provides medical care and treatment on an Inpatient basis for sick and injured persons at the patient's expense;
d) operates diagnostic and major surgical facilities either:
   1) on its premises; or
   2) in facilities available to the Hospital on a prearranged basis;
e) operates under the supervision of a staff of Physicians; and
f) provides 24 hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

a) a nursing home, convalescent home, or Skilled Nursing Facility;
b) a place for rest, custodial, educational or rehabilitory care;
c) a place for the aged; or
d) a place for drug addicts or alcoholics.

Hospital Expenses means:

a) Medicare Part A Eligible Expenses for treatment provided and billed by the Hospital;
b) after the Lifetime Reserve Period, Hospital Expenses of the kind that would have been covered by Medicare had Medicare Part A Benefits not been exhausted.

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Inpatient means Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any; for which a room and board charge is made.

Insured Person means an Eligible Person while he or she is covered by the Policy.

Medical Care means any professional or outpatient treatment, service, or supply which is covered by Medicare Part B.

Medicare means Title XVIII of the Social Security Act of 1965, as amended.

Medicare Eligible Expenses means health care expenses covered by Medicare to the extent recognized as reasonable by Medicare.

Medicare Part A Benefit Period means a period of time during which a Medicare beneficiary is Hospital or Skilled Nursing Facility Confined. A Medicare Part A Benefit Period:

a) begins when a Medicare beneficiary is admitted to a Hospital as an Inpatient; and
b) ends when he or she has not been Confined in a Hospital or Skilled Nursing Facility for 60 consecutive days.

Medicare Part A Deductible means the deductible amount which a Covered Person is required to pay under Medicare for the expenses Incurred at the beginning of a Medicare Part A Benefit Period.

Medicare Part B Deductible means the deductible amount which a Covered Person is required to pay under Medicare Part B each Calendar Year for Medicare Eligible Expenses.

Mental and Nervous Disorders means any neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Physician means any legally qualified Physician or surgeon or any medical practitioner of the healing arts who is acting within the scope of his or her license.

Policy Benefit Period for Medicare Part A Eligible Expenses means a Medicare Part A Benefit Period as defined, but does not include:

a) any Day of Confinement before the Covered Person's effective date; or
b) any Day of Confinement after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Policy Benefit Period for Medicare Part B Eligible Expenses means a Calendar Year quarter, but does not include any period of time:

a) before the Covered Person's effective date; or
b) after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

Related Policy means the Policyholder's Employee Health Plan.

Request means written request made on the forms we furnish for making the request.

Sickness means a person's Sickness or disease. However, Sickness first manifested before a Covered Person's effective date will be subject to the Policy's Pre-existing Condition Limitation.

Skilled Nursing Facility means an institution that:

a) operates pursuant to law;
b) in addition to room and board accommodations, is primarily engaged in providing skilled nursing care under the supervision of a Physician;
c) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate nurse (R.N.); and
d) maintains a daily medical record of each patient.

Skilled Nursing Facility does not mean any institution or part thereof which is used mainly as a home or place:

a) for the aged, or for rest, custodial or educational care;
b) for drug addicts or alcoholics;
c) for the treatment of Mental and Nervous Disorders.

Skilled Nursing Facility Expenses means Medicare Part A Eligible Expenses for services provided and billed by a Skilled Nursing Facility.

Totally Disabled means:

a) disabled by an Injury or Sickness that continuously Confines a Covered Person in a Hospital or Skilled Nursing Facility; or
b) if not Confined, continuously disabled by an Injury or Sickness which a Covered Person's Physician certifies prevents him or her from engaging in the normal activities of a person of like age and sex in good health.

Usual and Customary Charge means the prevailing charge made by most providers of a given service in the geographic area where the service is received. In no event will the Usual and Customary Charge exceed the actual amount charged.

We, us or our means the company named on the face page of this Policy.

INSURED PERSON PERIOD OF COVERAGE

Insured Person Effective Date: An Eligible Person will become covered by the Policy on:

a) the Policy Effective Date; or
b) The Policy Effective Date if we receive his or her Request for coverage prior to the Policy Effective Date; or
c) the first day of the month on or next following the date he or she becomes an Eligible Person; or
d) the first day of the month after we receive the Request, if it is received at any other time; or
e) with respect to an Eligible Person who attained Age 65 while covered by the Related Policy, the date stated in that Policy's "Conversion at Age 65" provision;

subject to payment of the required premium.

Request for Change in Insured Person's Coverage (if available under this Policy): If the Insured Person Requests to make a change in coverage, the change will become effective on the first day of the month after we receive the Request provided:

a) the Insured Person is eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the "Pre-existing Condition Limitation" provision.

Insured Person Termination: The Insured Person's coverage under the Policy will cease on the first to occur of:

a) the date the Policy is cancelled;
b) the Premium Due Date that the required premium for his or her coverage is not paid, subject to the Grace Period provision;
c) the date we or the Policyholder cancel coverage for a Class of Person to which he or she belongs;

However if the Insured Person is eligible for coverage under the Policy because he or she is the widow/widower of an active employee of the Policyholder the Insured Person's coverage will cease on the Premium Due Date on or next following the date he or she remarries.

Grace Period: A grace period of 31 days is allowed for payment of each premium due after the first premium. We will continue the insurance during the grace period. If an Eligible Person Incurs a covered loss during the Grace Period, the Policyholder will be liable to us for payment of any premium accruing during the period we continued coverage in force under the provision. The Grace Period will not continue coverage beyond a date stated in a Termination Provision.

COVERED SPOUSE PERIOD OF COVERAGE

SPOUSE COVERAGE WILL BE INDICATED ON THE SCHEDULE OF BENEFITS, IF APPLICABLE. IF THE SCHEDULE DOES NOT SHOW AN EFFECTIVE DATE FOR COVERAGE FOR THE SPOUSE, THEN HE OR SHE IS NOT COVERED UNDER THIS POLICY.

Covered Spouse Effective Date: An Eligible Person's Spouse will become covered by the Policy on:

a) the Policy Effective Date if we receive the Eligible Person's Request for the Spouse's coverage prior to the Policy Effective Date;
b) the first day of the month after we receive the Eligible Person's Request for the Spouse's coverage if it is received at any other time; or
c) with respect to a Spouse who attained Age 65 while covered by the Related Policy, the date stated in that Policy's "Conversion at Age 65" provision;

subject to payment of the required premium.

However, in no event will a Spouse become covered under the Policy:

a) before the date he or she qualifies as an Eligible Spouse; or
b) before the Eligible Person's effective date of coverage under either the Policy or the Related Policy.

Request for Change in Spouse's Coverage: If the Insured Person Requests to make a change in Spouse's coverage, the change will become effective on the first day of the month after we receive the Request provided:

a) the Spouse is eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the "Pre-existing Condition Limitation" provision.

Spouse Termination: Spouse coverage under the Policy will cease on the first to occur of:

a) the date the Policy is cancelled;
b) the Premium Due Date that the required premium for his or her coverage is not paid, subject to the Grace Period provision;
c) with respect to a Covered Spouse, the Premium Due Date on or next following the date he or she is Divorced from the Eligible Person, unless continued in accordance with the Spouse Continuation provision;
d) the date we or the Policyholder cancels coverage for a Class of Persons to which he or she belongs.

Spouse Continuation: If a Covered Spouse is Divorced while covered under the Policy, he or she may continue his or her coverage under the Policy. We must receive the Request and required premium to continue coverage under the Policy within 31 days of the date coverage terminates. Solely for the purpose of continuing the coverage under the Policy, the Spouse will be considered the Insured Person. However, this will not continue the coverage beyond a date the coverage would normally cease under a Spouse Termination provision of the Policy. Any coverage continued by this provision will terminate on the Premium Due Date on or next following the date the Spouse remarries.

Divorce/Divorced means annulment, dissolution of marriage, or legal separation from the Insured Person.

Covered Spouse Grace Period: A grace period of 31 days is allowed for payment of each premium due after the first. We will continue the insurance during the grace period. If a Covered Spouse Incurs a Covered loss during the Grace Period, the Policyholder will be liable to Us for payment of any premium accruing during the period We continued coverage in force under this provision. The grace period will not continue coverage beyond a date stated in the Termination Provision.

CONVERSION PRIVILEGE

APPLICABLE TO ALL PLANS

If a Covered Person's coverage under the Policy terminates because the Policy is cancelled and not replaced by another group policy, he or she will have the right to request conversion without giving medical evidence of insurability.

The Covered Person must:

a) make written application for conversion; and
b) pay the initial premium;

within 31 days after he or she ceases to be covered under the Policy.

The conversion policy:

a) will have the provisions, limitations and exclusions on the form we are issuing for this purpose at the time of conversion;
b) will base premiums on our rates in effect for new applicants of the Covered Person's Age, sex and geographic location at the time of conversion.

The Covered Person will be given a choice to elect conversion coverage which:

a) provides similar benefits to the Senior Medical Insurance Plan he or she had under the Policy; or
b) provides the minimum benefits required by law for a Medicare Supplement policy.

Conversion coverage issued to the Covered Person under the Conversion Privilege becomes effective on the date of his or her termination and will be in lieu of all other benefits under the Policy.

SENIOR MEDICAL INSURANCE PLAN BENEFITS

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

HOSPITAL CONFINEMENT BENEFIT

When a Covered Person is Confined in a Hospital, we will pay the benefit stated below. The Confinement must be a Medicare approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 60th Day of Hospital Confinement: For the first 60 Days of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except the Medicare Part A Deductible.

We cover the Medicare Part A Deductible if it is indicated on the Covered Person's Schedule of Benefits and Amounts.

61st to 90th Day of Hospital Confinement: From the 61st to 90th Day of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except a daily Coinsurance Charge equal to 25% of the Medicare Part A Deductible.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the Medicare Part A Coinsurance Charges the Covered Person Incurs from the 61st to 90th Day of Confinement.

Lifetime Reserve Period: Regular Medicare Hospital benefits end on the 90th Day of Confinement during a Medicare Part A Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If he or she uses the days, Medicare pays all Hospital Expenses Incurred during the Lifetime Reserve Period except a daily Coinsurance Charge equal to 50% of the Medicare Part A Deductible.

We pay the Medicare Part A Coinsurance Charges during the Lifetime Reserve Period. If the Covered Person saves the days for future use, we limit our daily payment to 50% of the Medicare Part A Deductible.

After the Lifetime Reserve Period: After the Lifetime Reserve Period ends (or would have ended if used), we will pay the percentage shown on Your Schedule of Benefits and Amounts of Hospital Expenses Incurred for each Day of Confinement during a Medicare Part A Benefit Period. Our payment period will be limited to an additional 365 Days of Confinement per person per lifetime.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

SKILLED NURSING FACILITY BENEFIT

When a Covered Person is Confined in a Skilled Nursing Facility, we will pay the benefit stated below. The Confinement must be a Medicare Approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 20th Day of Skilled Nursing Facility Confinement: For the first 20 Days of Approved Confinement during a Medicare Part A Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses.

We pay nothing from the 1st to 20th Day of Confinement.

21st to 100th Day of Skilled Nursing Facility Confinement: From the 21st to 100th Day of Approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Skilled Nursing Facility Expenses except a daily Coinsurance Charge equal to 12 1/2% of the Medicare Part A Deductible.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the Medicare Part A Coinsurance Charges the Covered Person Incurs from the 21st to 100th Day of Confinement.

EXTENDED SKILLED NURSING FACILITY BENEFIT

101st to 365th Day of Skilled Nursing Facility Confinement: After the 100th Day of Confinement during a Medicare Part A Benefit Period, Medicare benefits for Skilled Nursing Facility Confinements end.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the lesser of:

a) the daily amount stated in the Schedule; or
b) the room and board expense Incurred;

from the 101st to the 365th Day of Confinement.

Medicare Approved Confinement: Medicare only approves Skilled Nursing Facility Confinement that provides skilled, medically necessary care:

a) at a level meeting Medicare standards; and
b) commencing within 30 days of discharge from a Hospital Confinement of at least 3 consecutive days.

Our benefit under this plan is limited to those Days of Confinement which Medicare approves, or would have approved had Medicare benefits for the Confinement not been exhausted.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

MEDICAL CARE BENEFIT

After the Medicare Part B Deductible, Medicare pays the percentage shown in the Schedule of Benefits and Amounts of Medicare Part B Eligible Expenses. The portion of an expense which is more than Medicare considers reasonable:

a) is not a Medicare Part B Eligible Expense;
b) is not covered by Medicare; and
c) is not covered under this benefit.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for the portion of the Benefit, we will pay the percentage shown in the Schedule of Benefits and Amounts of the Medicare Part B Eligible Expenses after the Medicare Part B Deductible is met each Calendar Year. The Expenses must be Incurred by a Covered Person while covered by the benefit.

Expenses applied toward the Medicare Part B Deductible are not covered under this benefit.

MEDICARE PART B EXCESS CHARGES BENEFIT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, we will pay a percentage of the difference between:

a) the actual Medicare Part B charge as billed; and
b) the Medicare approved Part B charge;

after the Medicare Part B Deductible is met each Calendar Year. However, our payment will not exceed any charge limit action established by Medicare or state law. The expenses must be Incurred by a Covered Person while covered under this benefit.

However, we will not pay this benefit if:

a) the provider of the Medical Care accepts Medicare assignment; or
b) the service or supply is not covered by Medicare Part B.

The Out-of-Pocket Expense Amount is:

a) stated in the Schedule of Benefits and Amounts; and
b) applies to each Covered Person each Calendar Year.

Only Out-of-Pocket Expenses can be used to meet the Out-of-Pocket Expense Amount.

Out-of-Pocket Expenses means:

a) the portion of an expense, covered under Medicare Part B, which is more than Medicare considers reasonable, up to the Usual and Customary Charge; plus
b) expenses used to meet the Medicare Part B Deductible to the extent the Medicare Part B Deductible is not covered under the Policy.

Out-of-Pocket Expenses do not include expenses that are excluded or limited under the Policy.

Expenses Incurred During Last 3 Months of a Calendar Year: If:

a) a Covered Person Incurs Out-of-Pocket Expenses during the last 3 months of a Calendar Year; and
b) those expenses are applied to his or her Out-of-Pocket Expense Amount during the Calendar Year;

then, a Covered Person's Out-of-Pocket Expense Amount for the next Calendar Year will be reduced by the amount of those expenses.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

FOREIGN MEDICAL TREATMENT BENEFIT

Foreign Medical Treatment Benefit: We will pay the reasonable expense Incurred by a Covered Person for Foreign Medical Treatment provided he or she receives the first Foreign Medical Treatment:

a) while covered by this benefit; and
b) within the first 180 days of travel Outside of the United States per Calendar Year.

This benefit will be limited to treatment received during a Foreign Medical Treatment Benefit period. The Foreign Medical Treatment Benefit Period:

a) begins on the date of the first Foreign Medical Treatment; and
b) ends 90 consecutive days later.

This benefit will not cover any part of a Confinement that extends beyond that 90 day benefit period or any service or supply received after that 90 day benefit period.

This benefit will not cover Foreign Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the Untied States for 6 consecutive months or longer.

In addition, this benefit will not cover Foreign Medical Treatment if Medicare approves the treatment (in which event, the regular benefits of the Senior Medical Insurance Plan Benefits apply).

However, if:

a) a Covered Person must remain Outside of the United States more than 6 months because of an Injury or Sickness that prevents return to the United States; and
b) he or she has established a Foreign Medical Treatment Benefit Period for that Sickness or Injury within the first 180 days of travel, as stated above;

then, we will continue this benefit for that Sickness or Injury until the end of the Foreign Medical Treatment Benefit Period.

Foreign Medical Treatment means any medically necessary Confinement, service or supply received Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and America Samoa.

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Foreign Medical Treatment Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

FOREIGN TRAVEL EMERGENCY MEDICAL TREATMENT BENEFIT

Foreign Travel Emergency Medical Treatment Benefit: We will pay the percentage of the expenses Incurred by a Covered Person for Foreign Travel Emergency Medical Treatment if:

a) the Covered Person has satisfied the Calendar Year Deductible; and
b) the first expense was Incurred within the first 60 days of travel Outside of the United States.

Payment under the benefit will be limited to the Lifetime Maximum Benefit Amount.

The Percentage Payable, Deductible Amount and Lifetime Maximum Benefit Amounts are shown in the Schedule of Benefits and Amounts if a Covered Person's Schedule of Benefits and Amounts indicates coverages for this Benefit.

This benefit will not cover Foreign Travel Emergency Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Travel Emergency Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the United States for 6 consecutive months or longer.

In addition, this benefit will not cover Foreign Travel Emergency Medical Treatment if Medicare approves the treatment (in which event, the other benefits of the Plan apply.)

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Foreign Travel Emergency Medical Treatment Benefit.

Foreign Travel Emergency Medical Treatment means any medically necessary Confinement, service, or supply needed immediately due to Injury or Sickness of sudden and unexpected onset while the Covered Person is Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and American Samoa.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

PRIVATE DUTY NURSING BENEFIT
DURING HOSPITAL CONFINEMENT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the lesser of:

a) the expense Incurred; or
b) the Private Duty Nursing Maximum Benefit Amount;

for each shift of private duty nursing service, up to the Maximum Number of Shifts per Calendar Year.

The private duty nursing service must be provided to a person while he or she is:

a) covered under this benefit; and
b) Confined in a Hospital.

The private duty nursing services must be charged directly to a Covered Person by the Nurse and not charged by the Hospital.

Nurse means:

a) a Registered Graduate Nurse (R.N.); or
b) a Licensed Practical Nurse (L.P.N.);

who is not a member of a Covered Person's Family.

Family means a Covered Person's:

a) children, parents, spouse, brother or sister; or
b) spouse's children, parents, brother, or sister.

We will not pay for more than 3 shifts of private duty nursing services per day. A shift consists of at least 3 consecutive hours of nursing care. Shifts of more than 3 hours but less than 8 hours will be paid on a pro-rata basis.

The Maximum Benefit Amount and the Maximum Number of Shifts are stated in the Schedule, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

MEDICARE PART B DEDUCTIBLE BENEFIT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this benefit, We will pay the Medicare Part B Eligible Expenses Incurred by a Covered Person used to satisfy the Medicare Part B Deductible each Calendar Year.

The Medicare Part B Eligible Expenses must be Incurred by a Covered Person while he or she is covered under this benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

We will pay a percentage of the prescription drug expenses a Covered Person Incurs each Calendar Year in excess of the Prescription Drug Calendar Year Deductible. The prescription drug must be:

a) lawfully obtainable in the United States only upon a Physician's written prescription;
b) needed to treat the Covered Person's Injury or Sickness; and
c) purchased from a licensed pharmacy while he or she is covered by this benefit.

We will not pay more than the Maximum Benefit Amount per Calendar Year.

This benefit does not cover:

a) the administration of any prescription drug or other substance or the cost of equipment to administer the drug such as a syringe;
b) any prescription or refill which exceeds the greater of:
    1) a 34 day supply; or
    2) 90 day supply for mail order;
c) any experimental drug;
d) any prescription drug received while an inpatient in a Hospital, convalescent home, Skilled Nursing Facility or similar institution; or
e) the cost of any prescription drug to the extent the Covered Person is not legally obligated to pay.

The Percentage Payable, Deductible Amount and Benefit Amount are shown in the Schedule of Benefits and Amounts if the Covered Person is covered for this Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

AT HOME RECOVERY BENEFIT

If a Covered Person's Physician certifies that the Covered Person requires the services of a Care Provider for Home recovery from a Sickness, Injury or surgery for which a Home Care Plan of Treatment was approved by Medicare, and if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, then we will pay the lesser of:

a) the expense Incurred; or
b) the At-Home Recovery Maximum Amount per visit;

for short term At-Home Recovery Visits, up to the Maximum Benefit Amount per Calendar Year.

The At-Home Recovery Visits must be:

a) provided to a person while he or she is covered under this benefit;
b) primarily to provide services which assist in Activities of Daily Living;
c) provided on a visiting basis in the Covered Person's Home; and
d) provided while the Covered Person is receiving Medicare-approved home care services or within 8 weeks after the service date of the last Medicare home health care visit.

The Covered Person's attending Physician must certify that the specific type and frequency of At-Home Recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

This benefit will not pay for:

a) At-Home Recovery Visits paid for by Medicare or other government programs;
b) At-Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers, as defined;
c) more than the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment; or
d) more than 7 visits in any one week.

The Maximum Amount per visit, the Maximum visits per week and the Maximum Benefit Amount are shown in the Schedule of Benefits and Amounts if the Covered Person is covered for this Benefit.

Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

At-Home Recovery Visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a care provider is considered one visit.

Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

Home means a place used by the Covered Person as a place of residence. It may be the Covered Person's own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution, provided that such a place would qualify as a residence for Home Health Care services covered by Medicare. A Hospital or Skilled Nursing Facility is not considered the Covered Person's home.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

PREVENTIVE MEDICAL CARE BENEFIT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the actual charges up to the Medicare approved amount for expenses Incurred by the Covered Person for:

a) an annual clinical preventive medical history and physical examination (which may include Preventive Screening Tests or Services) and patient education to address preventive health measures; and
b) Preventive Screening Tests and Services, as defined; and
c) influenza vaccine administered at any appropriate time during the year; and
d) Tetanus and Diphtheria booster every 10 years; and
e) any other tests or preventive measures determined to be appropriate by the attending Physician.

The expenses must be Incurred by a Covered Person while covered by this benefit.

Our payment will be limited to the Maximum Benefit Amount per Calendar Year shown in the Schedule of Benefits and Amounts, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

Preventive Screening Tests and Preventive Services means one or more of the following, the frequency of which is considered medically appropriate:

a) fecal occult blood test and/or digital rectal examination;
b) mammogram;
c) dipstick urinalysis for hematuria, bacteriuria and proteinauria;
d) pure tone (air only) hearing screening tests, administered or ordered by a physician;
e) serum cholesterol screening (every 5 years);
f) thyroid function test; and
g) diabetes screening.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

HOSPICE CARE BENEFIT
APPLICABLE TO ALL PLANS

Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except coinsurance charges for Inpatient respite care, drugs and biologicals.

When a Covered Person elects to receive Hospice Care, we will pay the Medicare Coinsurance Charges which he or she Incurs.

The Hospice Care must:

a) be approved by Medicare; and
b) be received while covered by this benefit.

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Hospice Care benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

California:

Cancer Screenings Benefit

We will pay the Usual and Customary charges not covered by Medicare for mammography and cervical cancer screenings Incurred by a Covered Person each Calendar Year.

Colorado:

Mammography Benefit

We will pay for mammography coverage for routine and certain diagnostic screenings on a calendar year basis. Routine screening must include the following:

a) for women age 35-40, one baseline mammogram;
b) for women aged 40-50, one screening every two calendar years (once each calendar year for women with risk factors to breast cancer as determined by her physician); and
c) for women aged 50-65, one screening annually, on a calendar year basis.

If a Covered Person has not utilized the routine mammography benefit during a calendar year, then the benefit will apply to one diagnostic screening for that year.

If more than one diagnostic screening is provided in a calendar year, the policy's other diagnostic service benefits provisions will apply.

Diagnostic Screening as used in the benefit, means the use of procedures including physical examinations, radiological imaging, surgical techniques, and any new technologies approved by the board for detecting whether abnormalities of the breast are malignant or benign.

Screening means the conduct of physical examinations, visual inspections, or other medical tests exclusively for the purpose of ascertaining the existence of any physiological abnormality which might be indicative of the presence of disease. Screening includes diagnostic screening services.

Prostrate Cancer Screening Benefit

We will pay for an annual prostate screening for the early detection of prostate cancer:

a) for men over 50 years of age; and
b) for men over 40 years of age who are in high risk categories.

Coverage may not be subject to deductibles and must be the lesser of:

a) $65; or
b) the actual charge for the screening.

The screening may be performed by any qualified medical professional, including a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant.

The screening must include at least the following tests:

a) a prostate-specific antigen (PSA) blood test; and
b) a digital rectal examination.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Connecticut:

Home Health Aide Services Benefit

Medicare pays for home health care that is medically necessary if certain conditions are met. Covered services may include those of a home health aide.

When the services of a home health aide are not covered by Medicare, we will pay up to a maximum amount of $500 each Calendar Year for the Usual and Customary expenses that a Covered Person incurs for home health services, provided:

a) the Covered Person's attending Physician certifies in writing that such services are medically necessary;
b) such services are provided by a Connecticut licensed home health care agency; and
c) the Covered Person receives such services while covered by this benefit.

Mammography Screening Benefit

We will pay a Covered Person's expenses Incurred for one screening by Low-Dose Mammography for the presence of occult breast cancer for each Calendar Year.

Low-dose Mammography means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

Delaware:

Scalp Hair Prosthesis

We will provide coverage for medical or hospital expenses and also provide coverage for other prostheses, must provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. This coverage must follow the same limitations and guidelines as other prostheses, but such coverage need not exceed $500 per year.

This coverage may be subject to annual deductibles and co-insurance provisions as long as they are appropriate and consistent with those established for other benefits under the plan of coverage. Written notice of the availability of such coverage must be delivered to the insured, participant, policyholder, subscriber and beneficiary upon enrollment and annually thereafter.

The following terms are defined in this section as follows:

Prostheses: means artificial appliances used to replace lost natural structures. They include, but are not limited to, artificial arms, legs, breasts, or glass eyes.

Scalp Hair Prosthesis: means artificial substitutes for scalp hair that are made specifically for a specific individual.
Form PA-9411

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Delaware Continued:

The following terms are defined:

Provide coverage for medical formulas and foods, low protein modified formulas and modified food products that are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a physician.

The following terms are defined in this section as follows:

Inherited metabolic diseases: refers to diseases caused by an inherited abnormality of biochemistry. The words "inherited metabolic diseases" also include any diseases for which Delaware screens newborn babies.

Low protein modified formula or food product: means a formula or food product that is specially formulated to have less than 1 gram of protein per serving and intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. It does not include a natural food that is naturally low in protein.

Medical formula or food: means a formula or food that is intended for the dietary treatment of an inherited metabolic disease for which nutritional requirements and restrictions have been established by medical research and is formulated to be consumed or administered entirely under the direction of a physician.

Washington, D.C.:

Cancer Screening Benefit

We will pay the Usual and Customary charges Incurred by a Covered Person and not covered by Medicare for:

a) one mammography screening each Calendar Year; and
b) one cervical cancer screening each Calendar Year or more frequently if certified by a Physician that such cervical cancer screenings are medically necessary.

Hawaii:

Mental Health and Alcohol and Drug Abuse Treatment Benefit

Covered benefits for mental health, alcohol dependence and drug dependence shall be:

a) limited to those services certified by Medicare's licensed physician or psychologist as medically or psychologically necessary at the least costly appropriate level of care; and
b) not less than thirty days of in-hospital services per year. Each day of in-hospital services may be exchanged for two days of nonhosptial residential services, two days of partial hospitalization services or two days of day treatment services.

Physician or psychologist visits shall not be less than thirty visits per year to hospital or nonhospital facilities or to mental health outpatient facilities for day treatment or partial hospitalization services. The benefit for outpatient services shall not be less than twelve visits per year.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Hawaii (Continued):

Alcohol and Drug Dependence Benefit

Detoxification provided in a hospital or nonhospital facility which has a written affiliation agreement with a hospital for emergency, medical and mental health support services. Services are covered under the in-hospital services but not under the treatment episode limitation. Services include:

a) room and board;
b) diagnostic x-rays;
c) laboratory testing; and
d) drugs, equipment use, special therapies and supplies.

Alcohol and Drug Dependence Treatment is delivered through in-hospital, nonhospital residential or day treatment substance abuse services. A licensed physician or certified psychologist shall determine that this individual suffers from alcohol or drug dependence or both. Substance abuse services shall include services which are required for licensure and accreditation.

Excluded from this benefit are:

a) detoxification services;
b) educational programs to which drinking or drugged drivers are referred by the judicial system; and
c) services performed by mutual self-help groups.

Outpatient services for drug and alcohol dependence shall be provided under:

a) an individualized treatment plan approved by a licensed physician or certified psychologist; and
b) be reasonably expected to produce remission of the patient's condition.

Mental Illness Benefit

Mental illness benefits shall be limited to coverage for diagnosis and treatment of ental disorders. All mental helath services shall be provided under an individualised treatment plan approved by a licensed physician or psychologist and must be reasonably expected to improve the patient's condition.

In-hospital and nonhospital residential mental health services shall be provided in a hospital or nonhospital residential facility,

Mental health partial hospitalization shall be provided by a hospital or a mental health outpatient facility.

Mental health outpatient services are included as part of the covered outpatient services.

For this benefit, the following definitions apply:

Alcohol dependence means any use of alcohol which produces a pattern of pathological use causing impairment in social or occupational functioning or produces physiological dependency evidenced by physical tolerance or withdrawal.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Hawaii (Continued):

Alcohol or drug dependence outpatient services means alcohol or drug dependence nonresidential treatment provided on an ambulatory basis to patients with alcohol or drug dependence problems that includes psychiatric or psychological interventions prescribed and performed by state licensed physicians or psychologists who have been certified in accordance with set laws.

Certified sustance abuse staff means professionals and paraprofessional with current full certification as substance abuse counselors or program administrators.

Day treatment services means treatment services provided by a hospital, mental health outpatient facility, or nonhospital facility to patients who, because of their conditions, require more than periodic hourly service. Day treatment services shall be prescribed by a physician or licensed psycologist and carried out under the supervision of a physician or licensed psychologist. Day treatment services require:

a) less than twenty-four hours of care; and
b) a minimum of three hours in any one day.

Detoxification services means the process whereby a person intoxicated by alcohol or drugs or a person who is dependent upon alcohol or drugs or both is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug dependency factors, as determined by a licensed physician, while keeping the physiological risk to the person at a minimum.

Drug dependence means any pattern of pathological use of drugs causing impairment in social or occupational functioning and producing psychological or physilogical dependency or both, evidenced by physical tolerance or withdrawal.

Hospital means a facility licensed as a hospital by the department of health and accredited by the Joint Commission on Accreditation of Health Care Organizations.

In-hospital services means the provision of medical, nursing, or therapeutic services twenty-four hours a day in a hospital.

Mental health outpatient facility means a mental health establishment, clinic, institution, center, or community mental health center, that provides for the diagnosis, treatment, care, or rehabilitation of mentally ill persons, that has been accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

Mental illness or mental disorder means a syndrome of clinically significant psychological, biological, or behavioral abnormalities that results in personal distress or suffering, impairment of capacity for functioning, or both. Epilepsy, senility, mental retardation, or other developmental disabilities and addiction to or abuse of intoxicating substances do not in and of themselves constitute a mental disorder.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Hawaii (Continued):

Nonhospital facility means a facility for the care or treatment of alcohol dependent, drug dependent, or mentally ill persons, which has been accredited by the Joint Commission on Accreditation of Health Care Organizations of the Commission on Accreditation of Rehabilitation Facilities and, if residential, has been licensed as a special treatment facility by the department of health.

Nonhospital residential services means the provisions of medical, psychological, nursing, counseling, or therapeutic services to patients suffering from alcholo dependence, drug dependence or mental illness by a nonhospital residential facility, according to individualized treatment plans.

Partial hospitalization services means treatment services provided by a hospital or mental health outpatient facility to patients who, because of their conditions, require more than periodic hourly service. Partial hospitalization services shall be prescribed by a physician or licensed psychologist. Partial hospitalization services require less than twenty-four hours of care and a minimum of three hours in any one day.

Substance abuse services means the provisions of medical, psychological, nursing, counseling, or therapeutic services in response to a treatment plan for alcohol or drug dependence or both which sall include, when appropriate, a combination of aftercare and individual, group and familiy conseling services provided by certified substance abuse staff.

Treatment episode means one admission to an accrediated hospital or nonhospital facility, or office of a state-licensed physician or psychologist certified for treatment of alchol or drug dependence or both stipulated in a prescribed treatent plan and which would generally produce remission in those who complete the treatment. The prescribed treatment plan may include:

a) the provision of substance abuse services in more than one location; and
b) in-hospital, nonhospital residential, day treatment or alchol or drug dependence outpaitent services or any combination thereof. An admission for only detoxification services shall not constitue a treatment episode.

Iowa:

Mammography Benefit
We will pay a Covered Person's expenses Incurred for one screening by Low-dose mammography for the presence of occult breast cancer for each Calendar Year.

Low-dose Mammography means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Maine:

Mammography Coverage Benefit
We will pay the actual charge incurred by a Covered Person for one Screening Mammogram for the presence of occult breast cancer each Calendar Year to the extent that it is not covered by Medicare. This benefit is subject to any deductibles or coinsurance amounts.

Screening Mammogram means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

The definition of **Preventive Screening Tests and Preventive Services** definition (if any) has been deleted in its entirety and replaced by the following:

Preventive Screening Tests and Preventive Services means one or more of the following, the frequency of which is considered medically appropriate:

a) fecal occult blood test and/or digital rectal examination;
b) dipstick urinalysis for hematuria, bacteriuria and proteinauria;
c) pure tone (air only) hearing screening tests, administered or ordered by a physician;
d) serum cholesterol screening (every 5 years);
e) thyroid function test; and
f) diabetes screening.

Alcoholism and Drug Dependency Benefit
To the extent not covered by Medicare, we will pay for the expense incurred by a Covered Person for the treatment of alcoholism or drug dependency, subject to the following limitations per Calendar Year:

a) 30 days for inpatient or residential care in a Hospital or nonhospital residential facility; and
b) a maximum benefit amount of $1000 for outpatient visits.

We will not pay for more than the following per lifetime:

a) 60 days for inpatient or residential care in a Hospital or nonhospital residential facility; and
b) a maximum benefit amount of $25,000 for outpatient visits;

for the treatment of alcoholism or drug dependency, subject to all the rules and limitations of the Policy.

In no event will this rider provide coverage which duplicates Medicare benefits or which exceeds the maximum amount payable under the Policy.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Maine (Continued):

Mental and Nervous Disorder Benefit
To the extent not covered by Medicare, we will pay the expense incurred by a Covered Person for the treatment of the following Mental and Nervous Disorders:

a) schizophrenia;
b) bipolar disorder;
c) pervasive developmental disorder, or autism;
d) childhood schizophrenia;
e) psychotic depression, or involutional melancholia;
f) paranoia;
g) panic disorder; and
h) major depressive disorder.

The benefit will be limited to:

a) 60 days for inpatient care; and
b) 50% of the reasonable and customary charge for outpatient or day treatment care, or any combination of the two, to a maximum of $2,000;

per calendar year, with a lifetime maximum amount of $100,000.

We will pay the expense incurred by a Covered Person for treatment of all other Mental and Nervous Disorders the same as any other Sickness.
This benefit will be limited to:

a) the coinsurance amount applicable to any other Sickness, for inpatient or day treatment to a maximum of 30 days; and
b) 50% of the reasonable and customary charge for outpatient treatment care, to a maximum of $1,500;

per calendar year, with a lifetime maximum of $50,000.

Massachusetts:

Confinement for Treatment of Alcoholism Benefit
We will pay the expense incurred for the first 30 days per Calendar Year of Confinement in a hospital or specialized facility for Inpatient treatment of alcoholism, to the extent not covered by Medicare.

Confinement for Treatment of Mental and Nervous Disorders Benefit
We will pay the expense incurred for Confinement in Hospital for the treatment of Mental and Nervous Disorders the same as any other Sickness. However, if the Covered Person is confined to:

a) a mental hospital under the direction and supervision of the Department of Mental Health of the Commonwealth of Massachusetts; or
b) a private mental hospital licensed by the Department of Mental Health of the Commonwealth of Massachusetts;

we will limit our payment to the expense incurred for up to 60 days of Confinement per Calendar Year, to the extent not covered by Medicare.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Massachusetts (Continued):

Outpatient Treatment of Alcoholism Benefit
We will pay the expense incurred for outpatient treatment of alcoholism to the extent not covered by Medicare up to a maximum of $500 per Calendar Year.

Outpatient Treatment of Mental and Nervous Disorders Benefit
We will pay the expense incurred for outpatient treatment of Mental and Nervous Disorders to the extent not covered by Medicare provided by:

a) a comprehensive health service organization;
b) a licensed or accredited hospital;
c) a community mental health center, mental health clinic, or day care center which furnishes mental health services, if approved by the Department of Mental Health of the Commonwealth of Massachusetts; or
d) consultations or diagnostic or treatment sessions provided by:
   1. a fully licensed psychotherapist who devotes a substantial amount of time to the practice of psychiatry;
   2. a licensed psychologist;
   3. a licensed independent clinical social worker; and
   4. a certified clinical specialist in psychiatric and mental health nursing, provided such services are within the scope of his or her practice;

in excess of the Medicare approved amount.

If Medicare denies payment for treatment, we will still provide coverage up to $500 maximum per Calendar Year.

Mammography Screening Benefit
We will pay the expense incurred by a Covered Person for one screening by Low-dose mammography each Calendar Year to the extent that it is not covered by Medicare.

Low-dose Mammography means the x-ray examination of the breast using equipment specifically for mammography with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Cytologic Screening Benefit
We will pay the expense incurred by a Covered Person for one Cytologic Screening (Pap smear) per Calendar Year to the extent that it is not covered by Medicare.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Massachusetts (Continued):

Enteral Formulas Benefit
We will pay the expense incurred for non-prescription enteral formulas medically necessary for the treatment of malabsorption caused by:

a) Chrohn's disease;
b) ulcerative colitis;
c) gastroesophageal reflex;
d) gastrointestinal motility; or
e) chronic intestinal pseudo-obstruction;

to the extent not covered by Medicare.

Montana:

Mammography Screening Benefit
We will pay the lesser of:

a) $70; or
b) the actual charge incurred by a Covered Person;

for one screening by Low-dose Mammography for the presence of occult breast cancer for each Calendar Year to the extent that it is not covered by Medicare.

Low-dose Mammography means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

New Jersey:

Prostrate Cancer Screening Benefit
We will pay for an annual diagnostic examination including but not limited to, a digital rectal examination and a prostate-specific antigen test for men age:

a) 50 and over who are asymptomatic; and
b) 40 and over with a family history of prostrate cancer or other prostrate cancer risk factors.

This benefit will be provided to the same extent as for any other medical condition under this policy.

At Home Recovery Benefit
If a Covered Person's Pychisican certifies that the Covered Person requires the services of a Care Provided for Home recovery or Rehabilitation from a Sickness, Injury or surgery, then we will pay the lesser of:

a) the expense Incurred; or
b) the At Home Recovery Maximum Amount per visit;

for short term At Home Recovery Visits, up to the Maximum Benefit Amount per Calendar Year.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

New Jersey (Continued):

The At Home Recovery Visits must be:

a) provided to a person while he or she is covered under this benefit;
b) primarily to provide services which assist in Activities of Daily Living;
c) provided on a visiting basis in the Covered Person's Home.

This benefit will not pay for:

a) At Home Recovery Visits paid for by Medicare or other government programs;
b) At Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers, as defined;
c) More than 7 visits in any one week.

Definitions for this benefit are as follows:

Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

At Home Recovery Visit means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a care provider is considered one visit.

Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

Home means a place used by the Covered Person as a place of residence. It may be the Covered Person's own dwelling, an apartment, a relatives' home, a home for the aged or some other type of institution. A Hospital or Skilled Nursing Facility is not considered the Covered Person's home.

Rehabilitation means aiding a patient in order to assist in the development of independent living capabilities in order to attain reduction of physical or mental disability.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

New Jersey (Continued):

Preventive Medical Care Benefit
We will pay the actual charges up to the Medicare approved amount for expenses Incurred by the covered Person for:

a) an annual clinical preventive medical history and physical examination (which may include Preventive Screening Tests or Services) and patient education to address preventive health measures; and
b) Preventive Screening Tests and Services, as defined: and
c) Influenza vaccine administered at any appropraite time during the year; and
d) Tetanus and Diptheria booster every 10 years; and
e) other tests or preventive measures determined to be appropriate by the attending Physician.

The expenses must be Incurred by a Covered Person while covered under this benefit.

Our payment will be limited to the Maximum Benefit Amount per Calendar ear shown in the Schedule.

Preventive Screening Tests and Preventive Services means one or more of the following, the frequency of which is considered medically appropriate:

a) fecal occult blood test and/or digital rectal examiniation;
b) dipstick urinalysis for hematuria, bacteriuria and proteinauria;
c) pure tone (air only) hearing screening tests, administered or ordered by a physician;
d) serum cholesterol screening (every 5 years);
e) thyroid function test; and
f) diabetes screening.

Mammography Coverage Benefit
We will pay the actual charge incurred by a Covered Person for one screening by Low-Dose Mammography for the presence of occult breast cancer for each Calendar Year to the extent that it is not covered by Medicare.

Low-Dose Mammography means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

Wilm's Tumor Benefit
We will cover the expenses Incurred by a Covered Person for the treatment of Wilm's Tumor the same as any other covered Sickness to the extent that it is not covered by either Medicare Part A or Part B.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Pennsylvania:

Phenylketonuria Treatment Benefit
We will cover the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a Physician.

Rhode Island:

At Home Recovery Benefit

If a Covered Person's Physician certifies that the Covered Person requires the services of a Care Provider for Home recovery from a Sickness, Injury or surgery for which a Home Care Plan of Treatment was approved by Medicare, then we will pay the lesser of:

a) the expense Incurred; or
b) the At-Home Recovery Maximum Amount per visit;

for short term At-Home Recovery visits, up to the Maximum Benefit Amount per Calendar Year.

The At-Home Recovery Visits must be:

a) provided to a person while her or she is covered under this benefit;
b) primarily to provide services which assist in Activities of Daily Living;
c) provided on a visiting basis in the Covered Person's Home; and
d) provided while the Covered Person is receiving Medicare-approved home care services or within the Covered Person's attending Physician must certify that the specific type and frequency of At-Home Recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

This benefit will not pay for:

a) At-Home Recovery Visits paid for by Medicare or other government programs;
b) At-Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers, as defined;
c) more than the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment; or
d) more than 7 visits in any one week.

Maximum Amount per visit, the Maximum visits per week and the Maximum Benefit Amount are shown below:

Maximum Amount per visit: $40
Maximum visits per week: 7
Maximum Benefit Amount: $1,600 per Calendar Year

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Rhode Island (Continued):

Definitions for this benefit are:

Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and hanging bandages or other dressings.

At-Home Recovery Visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is considered one visit.

Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

Home means a place used by the Covered Person as a place of residence. It may be the Covered Person's own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution, provided that such a place would qualify as a residence for Home Health Care services covered by Medicare. A Hospital or Skilled Nursing Facility is not considered the Covered Person's home.

Also for the residents of Rhode Island: Medical coverage must be provided for serious mental illness on the same basis as coverage for other illnesses and diseases. Coverage must include the same durational limits and deductibles as for other illnesses and diseases. These health care benefits apply only to services delivered within the state of Rhode Island.

Serious Mental Illness means any mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the Insured Person with the illness. The term includes, but is not limited to:

a) schizophrenia;
b) schizoaffective disorder;
c) delusional disorder;
d) bioplar affective disorders;
e) major depression
f) obsessive compulsive disorder.

Medical coverage means inpatient hospitalization and outpatient medication visits. Inpatient coverage in cases where continuous hospitalization is medically necessary is limited to 90 consecutive days.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

South Dakota:

Mammography Benefit
To the extent not covered by Medicare, we will pay the expense incurred for one screening by Low-dose Mammography for the presence of occult breast cancer for each Calendar Year as follows:

a) for women aged 35-39, one baseline mammogram;
b) for women aged 40-49, one screening every two years; and
c) for women aged 50 or over, one screening annually.

Low-dose Mammography means x-ray examinations of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

Phenylketonuria Treatment Benefit
We will cover the expenses Incurred by a Covered Person for the treatment of Phenylketonuria the same as any covered Sickness to the extent that it is not covered by either Medicare Part A or Part B.

Texas:

Mammography Screening Benefit
We will pay a Covered Person's expenses Incurred for one screening by Low-dose Mammography for the presence of occult breast cancer each Calendar Year as follows:

a) 20% of the Usual and Customary Charge for screening which is not covered by Medicare; or
b) 20% of the Medicare Eligible Expenses for screening which is covered by Medicare after the Medicare Part B Deductible is met.

Low-dose Mammography means x-ray examination of the breast using equipment with an average radiation exposure delivery of less than one rad mid-breast, with 2 views for each breast.

Virginia:

Pap Smear Benefit
We will pay the expenses incurred by a Covered Person for one pap smear per Calendar Year, including those performed by any FDA-approved gynecologic cytology screening technologies. Payment under this benefit will not duplicate payments made under any other benefit of the Policy or by Medicare.

Mammography Coverage Benefit

a) for women aged 35-39, we will pay for one baseline mammogram;
b) for women aged 40-49, we will pay for one mammogram screening every 2 years; and
c) for women aged 50 and over, we will pay for one mammogram screening annually.

Coverage may be limited to $50 per screening and is subject to dollar limits, deductibles and coinsurance which are no less favorable than for physical illness generally.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Virginia (Continued):

Mammograms must be:

a) ordered by a health care practitioner acting within the scope of his or her license;
b) performed by a registered technologist;
c) interpreted by a qualified radiologist;
d) performed under the direction of a person licensed to practice medicine and surgery, and certified by the American Board of Radiology or an equivalent examining body; and
e) a copy of the mammogram report must be sent or delivered to the health practitioner who ordered it.

The equipment used to perform the mammogram must meet the Virginia Department of Health radiation protection regulations and the film must be retained by the radiolgic facility performing the examination.

Wisconsin:

Mental and Nervous Disorders, Alcoholism and Drug Abuse Benefit
The Covered Person will receive a benefit when we receive proof that, while insured, he or she Incurs expenses for the treatment of Mental and Nervous Disorder, alcoholism or drug abuse. The benefit will be equal to the actual charges Incurred for Inpatient, outpatient services and Transitional Treatment arrangements up to the following maximums:

a) inpatient services up to a Calendar Year maximum of the lesser of:
   1. the first 30 days of Confinement in a Hospital; or
   2. the first $7,000.00 of charges minus a 10% copayment;
b) outpatient services up to a Calendar Year maximum of $2,000.00 minus a 10% copayment;
c) Transitional treatment arrangements up to a Calendar Year maximum of $3,000.00 minus a 10% copayment.

The combined maximum benefit payable under a), b) and c) will be equal to $7,000.00 each Calendar Year.

Transitional Treatment means services for the treatment of Nervous or Mental Disorders or alcoholism or other drug abuse problems that are provided to a Covered Person in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services.

Only those expenses not eligible under Medicare will be considered for reimbursement under this benefit.

Chiropractic Services Benefit
We will pay 100% of the Usual and Customary Charges Incurred by the Covered Person for the diagnosis and treatment of a condition or complain by a licensed chiropractor while insured by us. Treatment must be within the scope of the chiropractor's professional license and must be for a condition that would have been covered if provided by a Physician or osteopath.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS (Continued)

With respects to residents of the following states, the following benefits are added to the Policy and Certificate:

Wisconsin (Continued):

Equipment and Supplies for Diabetes Treatment Benefit
The Covered Person will receive a benefit if expenses are incurred for the following:

a) the installation and use of an insulin infusion pump;
b) other equipment or supplies in the treatment of diabetes;
c) medication used to control diabetes, including, but not limited to, insulin;
d) diabetic self-management education programs.

We will pay 100% of the Usual and Customary charges Incurred even if Medicare refuses to pay. However, any benefit paid will not exceed the expense actually Incurred and will not duplicate payments made under any other provisions of this Policy or by Medicare.

Benefits for an insulin infusion pump are limited to the purchase of one pump per Calendar Year. The Covered Person must use an infusion pump for 30 days prior to the initial, but not replacement, purchase.

Kidney Disease Treatment Benefit
We will pay the expense Incurred for medically necessary Hospital Confinement and outpatient kidney disease treatment that the Covered Person receives while insured with us. Coverage is limited to expenses for dialysis, transplantation and donor-related services which are eligible under Medicare.

The maximum benefit payable per Calendar Year is $30,000.

Non-Medicare Approved Skilled Nursing Facility Benefit
We will pay the expense Incurred for treatment received by the Covered Person while Confined in a non-Medicare approved licensed Skilled Nursing Facility for which no Medicare Part A benefits are payable. The Confinement in the licensed Skilled Nursing Care Facility must be because of the same or related Injury or Sickness for which the Covered Person was previously treated.

The daily payable rate shall be no less than the maximum daily rate established for Skilled Nursing Facility care in that facility by the Department of Health and Social Services. The maximum we will pay is limited to 30 days per benefit period.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

BLOOD DEDUCTIBLE BENEFIT
APPLICABLE TO ALL PLANS

Medicare does not cover the first 3 pints of blood received under Medicare Part A or Medicare Part B each Calendar Year.

We pay the expenses a Covered Person Incurs for these first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations:

a) under Medicare Part A, except to the extent benefits for the Part B Blood Deductible have been paid; or
b) under Medicare Part B, except to the extent benefits for the Part A Blood Deductible have been paid.

The expenses must be Incurred while a Covered Person is covered by this benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

EXTENSION OF BENEFITS APPLICABLE TO ALL PLANS

If a Covered Person is Totally Disabled on the date his or her coverage terminates, we will extend the Policy Benefit Period for expenses Incurred as the result of that disability, subject to all Policy benefit provisions, exclusions, and limitations.

For Medicare Part A Eligible Expenses: A Policy Benefit Period for Medicare Part A Eligible Expenses which is established prior to termination extends until the first to occur of:

a) the date the Covered Person has not been Confined in a Hospital or Skilled Nursing Facility for a period of 60 consecutive days; or
b) the 365th day after termination.

If a Covered Person's coverage terminates while he or she is receiving approved Hospice Care, the Hospice Care benefits of the Policy will continue until the end of the Hospice Care benefit period, as defined by Medicare.

For Medicare Part B Eligible Expenses: The Policy Benefit Period for Medicare Part B Eligible Expenses extends until the end of the Calendar Year quarter following termination as shown below:

Termination Month	**Extension Date**
January, February, March	June 30 of same year
April, May, June	September 30 of same year
July, August, September	December 31 of same year
October, November, December	March 31 of next year.

GENERAL LIMITATIONS APPLICABLE TO ALL PLANS

Limitation: If a Covered Person has not enrolled in both Medicare Part A and Part B, we will pay the benefits under the Policy as if he or she had enrolled in both parts of Medicare.

PRE-EXISTING CONDITION LIMITATION
APPLICABLE TO ALL PLANS

Pre-existing Condition means any Injury or Sickness for which a Covered Person received medical advice or treatment within the 6 month period immediately before:

a) his or her effective date of coverage; or
b) the effective date of an increase in coverage;

whichever is applicable.

Conditions Prior to Effective Date: During the first 6 months from a Covered Person's effective date of insurance, expenses Incurred for Pre-existing Conditions are not covered.

Change from a Related Policy: If a Covered Person's coverage has converted without interruption:

a) from the Related Policy;
b) to this Policy;

we will credit toward satisfaction of the above Pre-Existing Condition Limitation the period that he or she was continuously covered by the Related Policy immediately before the conversion. Any expenses Incurred which are payable under an Extension of Benefits provision of the Related Policy will not be payable under this Policy.

Replacement Coverage: If the Covered Person:

a) has purchased coverage under this Policy in order to replace coverage under a prior Senior Medical Insurance Plan policy; and
b) he or she provides proof of coverage under such prior Senior Medical Insurance Plan policy;

we will credit toward satisfaction of this Policy's Pre-existing Condition Limitation the period that he or she was continuously covered by the prior Senior Medical Insurance Plan policy immediately before his or her effective date under this Policy.

However, if benefits under this Policy are greater than those provided by the prior policy, the 6 month Pre-existing Condition Limitation of this Policy will apply only to the increased benefits.

Conditions Prior to Effective Date of Increase in Coverage: During the first 6 months following the date a Covered Person makes a change in coverage that increases benefits, the increased portion of the benefit will not be payable for expenses Incurred due to Pre-existing Conditions.

This Limitation will not apply to any increase in coverage due to changes in Medicare benefits.

GENERAL EXCLUSIONS
APPLICABLE TO ALL PLANS

The Policy does not cover:

1. any expense that is:
    a) not a Medicare Eligible Expense; or
    b) beyond the limits imposed by Medicare for such expense; or
    c) excluded by name or specific description by Medicare;

    except as specifically provided under the Policy;
2. any portion of a covered expense to the extent paid by Medicare;
3. any benefits payable under one benefit of the Policy to the extent payable under another benefit of the Policy; and
4. covered expenses Incurred after coverage terminates except as stated in the Extension of Benefits provision.

CLAIM PROVISIONS
APPLICABLE TO ALL PLANS

Notice of Claim: The person who has the right to claim benefits must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include the Insured Person's name and the Policy number. Send it to The Hartford's approved Claims Administrator.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if written proof of the occurrence, character and extent of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

a) the end of each month of our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any benefit due:

a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefits due and not assigned, to the Insured Person, if living. Otherwise, we will pay:

a) any benefits due for a loss which occurred prior to the Insured Person's death to his or her estate;
b) any benefits due to a Covered Dependent's loss to the Dependent.

If a benefit due is payable to a minor, it will be paid to his or her guardian. If a benefit due is payable to the Insured Person's Dependent and he or she dies, it will be paid to the Dependent's estate. If a benefit due is payable to:

a) the Dependent's estate;
b) a minor; or
c) a person not competent to give valid release for payment;

we may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to the Insured Person by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

If the Insured Person provides us with a Written Release to do so, we may, at our option, pay benefits directly to the institution or person rendering:

a) Hospital services; or
b) nursing, medical, or surgical services;

unless the Insured Person or the person to whom the benefit is payable requests otherwise in writing no later than the time the proof of loss is filed with us.

Written Release means any written direction from the Insured Person to pay benefits to the institution or person rendering the service. We will not require that the services be rendered by a particular institution or person.

CLAIM PROVISIONS (Continued)
APPLICABLE TO ALL PLANS

Assignment: The Insured Person may assign the benefits of this Policy to the institution, or person rendering service as allowed in the Payment of Claims provision. The Insured Person may not assign the Policy in any other way or to any other person.

Physical Examinations: While a claim is pending we have the right at our expense to have the person who has a loss examined by a Physician when and as often as we feel is necessary.

Legal Actions: Legal action cannot be taken against us:

a) before 60 days following the date proof of loss is sent to us;
b) after 3 years following the date proof of loss is due.

Changes to Medicare: Benefits are adjusted annually to reflect changes in the federal government's Medicare program. These changes may cause increases or decreases in benefit amounts payable under the Policy.

The amount of Medicare Eligible Expenses covered as the result of an increase in our benefits cannot be used to satisfy any deductible under the Senior Medical Insurance Plan Benefits.

However, this increase in benefits due to a reduction in Medicare payments will not apply if the provider accepts Medicare Assignment for the Medical Care.

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A STANDARDIZED MEDICARE SUPPLEMENT PLAN.

CERTIFICATE OF SENIOR MEDICAL INSURANCE PLAN BENEFITS

Hartford Life and Accident Insurance Company
Hartford, Connecticut

Policyholder Name: County of Fresno

Policy Number: AGP- 3229

30 Day Right to Examine Certificate: We urge you to examine this Certificate closely. If you are not satisfied, return it to us within 30 days of the date of its delivery. In that event, we will consider it void from the Certificate effective date and any premium paid will be refunded to the Policyholder. Any claims paid will be deducted from the refund.
Notice to buyer: The Policy may not cover all of the costs associated with medical care incurred by you during the period of coverage. You are advised to review carefully all Policy limitations contained in this certificate.

Renewability: Except for material misrepresentation, coverage under the Policy will continue by timely payment of premium until the first to occur of:

a) the date the Policy is cancelled; or
b) the date the Insured Person ceases to qualify within a class of persons eligible for coverage under the Policy.

We have issued a Policy to the Policyholder. The provisions of the Policy which are important to you are summarized in this Certificate; consisting of this form, the Schedule with the most recent effective date and any additional forms which have been made a part of this Certificate. This Certificate replaces any certificates which may have been given to you earlier for 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. The Policy may be inspected at the office of the Policyholder.

Lisa Levin, *Secretary*

Michael Concannon, *President*

YOUR SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH YOU AND OR YOUR COVERED SPOUSE ARE COVERED. THIS CERTIFICATE MAY DESCRIBE BENEFITS NOT INCLUDED IN YOUR PARTICULAR PLAN. PLEASE CHECK YOUR SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY.

SEQUENCE OF CONTENTS

GENERAL DEFINITIONS

(Not All Definitions Are Applicable To A Covered Person's Coverage Under The Policy, Please Check Your Schedule Of Benefits)

Age means a Covered Person's attained age on any premium due date.

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Confined or Confinement means being an Inpatient in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

due to Sickness or Injury.

Covered Person means you, while covered under this Policy or your Eligible Dependent if he or she is covered under this Policy.

Day of Confinement means a day of Inpatient Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

for which a daily room and board charge is made for a full Day of Confinement.

Hospice Care means Medicare approved medical and support services needed to manage symptoms and relieve the pain of a terminal illness. The services must be provided through a Medicare approved Hospice Care Program. Hospice Care includes but is not limited to:

a) nursing care, therapies, medical supplies and appliances;
b) short-term Inpatient respite care; and
c) Physician, home health aide and counseling services.

GENERAL DEFINITIONS (Continued)

(Not All Definitions Are Applicable To A Covered Person's Coverage Under The Policy, Please Check Your Schedule Of Benefits)

Hospital means an institution which:

a) is approved by Medicare;
b) operates pursuant to law;
c) primarily and continuously provides medical care and treatment on an Inpatient basis for sick and injured persons at the patient's expense;
d) operates diagnostic and major surgical facilities either:
   1) on its premises; or
   2) in facilities available to the Hospital on a prearranged basis;
e) operates under the supervision of a staff of Physicians; and
f) provides 24 hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof which is used primarily as:

a) a nursing home, convalescent home, or Skilled Nursing Facility;
b) a place for rest, custodial, educational or rehabilitory care;
c) a place for the aged; or
d) a place for drug addicts or alcoholics.

Hospital Expenses means:

a) Medicare Part A Eligible Expenses for treatment provided and billed by the Hospital;
b) after the Lifetime Reserve Period, Hospital Expenses of the kind that would have been covered by Medicare had Medicare Part A Benefits not been exhausted.

Incurred means the date a Covered Person received the particular treatment, service, or supply that gave rise to an expense.

Injury means bodily Injury of a person resulting from accident. However, Injury that occurred prior to a Covered Person's effective date of coverage will be subject to the Policy's Pre-existing Condition Limitation.

Inpatient means Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

for which a room and board charge is made.

Medical Care means any professional or outpatient treatment, service, or supply which is covered by Medicare Part B.

Medicare means Title XVIII of the Social Security Act of 1965, as amended.

Medicare Eligible Expenses means health care expenses covered by Medicare to the extent recognized as reasonable by Medicare.

Medicare Part A Benefit Period means a period of time during which a Medicare beneficiary is Hospital or Skilled Nursing Facility Confined. A Medicare Part A Benefit Period:

a) begins when a Medicare beneficiary is admitted to a Hospital as an Inpatient; and

b) ends when he or she has not been Confined in a Hospital or Skilled Nursing Facility for 60 consecutive days.

GENERAL DEFINITIONS (Continued)

(Not All Definitions Are Applicable To A Covered Person's Coverage Under The Policy, Please Check Your Schedule Of Benefits)

Medicare Part A Deductible means the deductible amount which a Covered Person is required to pay under Medicare for the expenses Incurred at the beginning of a Medicare Part A Benefit Period.

Medicare Part B Deductible means the deductible amount which a Covered Person is required to pay under Medicare Part B each Calendar Year for Medicare Eligible Expenses.

Mental and Nervous Disorders means any neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Physician means any legally qualified Physician or surgeon or any medical practitioner of the healing arts who is acting within the scope of his or her license.

Policy Benefit Period for Medicare Part A Eligible Expenses means a Medicare Part A Benefit Period as defined, but does not include:

a) any Day of Confinement before the Covered Person's effective date; or
b) any Day of Confinement after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

Policy Benefit Period for Medicare Part B Eligible Expenses means a Calendar Year quarter, but does not include any period of time:

a) before the Covered Person's effective date; or
b) after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

Related Policy means the Policyholder's Employee Group Health Plan.

Request means written request made on the forms we furnish for making the request.

Sickness means a person's Sickness or disease. However, Sickness first manifested before a Covered Person's effective date will be subject to the Policy's Pre-existing Condition Limitation.

Skilled Nursing Facility means an institution that:

a) operates pursuant to law;
b) in addition to room and board accommodations, is primarily engaged in providing skilled nursing care under the supervision of a Physician;
c) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate nurse (R.N.); and
d) maintains a daily medical record of each patient.

Skilled Nursing Facility does not mean any institution or part thereof which is used mainly as a home or place:

a) for the aged, or for rest, custodial or educational care;
b) for drug addicts or alcoholics;
c) for the treatment of Mental and Nervous Disorders.

GENERAL DEFINITIONS (Continued)

(Not All Definitions Are Applicable To A Covered Person's Coverage Under The Policy, Please Check Your Schedule Of Benefits)

Skilled Nursing Facility Expenses means Medicare Part A Eligible Expenses for services provided and billed by a Skilled Nursing Facility.

Totally Disabled means:

a) disabled by an Injury or Sickness that continuously Confines a Covered Person in a Hospital or Skilled Nursing Facility; or
b) if not Confined, continuously disabled by an Injury or Sickness which a Covered Person's Physician certifies prevents him or her from engaging in the normal activities of a person of like age and sex in good health.

Usual and Customary Charge means the prevailing charge made by most providers of a given service in the geographic area where the service is received. In no event will the Usual and Customary Charge exceed the actual amount charged.

We, us or our means the company named on the face page of this Certificate.

You or Your means the person named on the Schedule.

INSURED PERSON PERIOD OF COVERAGE

Insured Person Effective Date: You will become covered by the Policy on the Effective Date of the Schedule that first shows coverage for you.

Request for Change in Insured Person's Coverage (if available under the Policy): If you Request to make a change in your coverage, the change will become effective on the first day of the month after we receive the Request provided:

a) you are eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the "Pre-existing Condition Limitation" provision.

Insured Person Termination: Your coverage will cease on the first to occur of:

a) the date the Policy is cancelled;
b) the Premium Due Date that the required premium for your coverage is not paid, subject to the Grace Period provision;
c) the date we or the Policyholder cancel coverage for a Class of Person to which you belong; or

However, if you are eligible for coverage under the Policy because You are the widow/widower of an active or retired employee of the Policyholder, your coverage will cease on the Premium Due Date on or next following the date You remarry.

INSURED PERSON PERIOD OF COVERAGE (Continued)

Individual Grace Period: A grace period of 31 days is allowed for payment of each premium due after the first premium. We will continue the insurance during the grace period. If a Covered Person Incurs a covered loss during the grace period, you will be liable to us for payment of any premium accruing during the period we continued coverage in force under this provision. The grace period will not continue coverage beyond a date stated in a Termination provision.

COVERED SPOUSE PERIOD OF COVERAGE

If you are insured for Spouse coverage, it will be indicated on your Schedule of Benefits.

Description of Eligible Spouse
Your Spouse who is entitled to Medicare by reason of Age, provided he or she is not legally separated or divorced from you.

Covered Spouse Effective Date: Your Eligible Spouse will become covered by the Policy on the Effective Date of the Schedule that first shows coverage for him or her. If your Schedule does not show an effective date for coverage for your Spouse, then he or she is NOT covered under the Policy.

Request for Change in Spouse Coverage (if available under the Policy): If you Request to make a change in your Spouse's coverage, the change will become effective on the first day of the month after we receive the Request provided:

a) Your Spouse is eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the "Pre-existing Condition Limitation" provision.

Spouse Coverage Termination: Dependent coverage under the Policy will cease on the first to occur of:

a) the date the Policy is cancelled;
b) the Premium Due Date that the required premium for his or her coverage is not paid, subject to the Covered Spouse Grace Period provision;
c) the Premium Due Date on or next following the date he or she is Divorced from you, unless continued in accordance with the Spouse Continuation provision;
d) the date Your coverage ceases under the Policy;
e) the date we or the Policyholder cancels coverage for a Class of Persons to which you belong.

Spouse Continuation: If a Covered Spouse is Divorced while covered under the Policy, he or she may continue his or her coverage under the Policy. We must receive the Request and required premium to continue the coverage under the Policy within 31 days of the date coverage terminates.

Solely for the purpose of continuing the coverage under the Policy, your Spouse will be considered the Insured Person. However, this will not continue the coverage beyond a date the coverage would normally cease under the Spouse Termination provision of the Policy. Any coverage continued by this provision will terminate on the Premium Due Date on or next following the date your Spouse remarries.

Divorce/Divorced means annulment, dissolution of marriage, or legal separation from the Insured Person.

COVERED SPOUSE PERIOD OF COVERAGE (Continued)

If you are insured for Spouse coverage, it will be indicated on your Schedule of Benefits.

Covered Spouse Grace Period: A Grace Period of 31 days is allowed for payment of each premium due after the first. We will continue the insurance during the Grace Period. If a Covered Spouse Incurs a covered loss during the Grace Period, you will be liable to us for payment of any premium accruing during the period we continued coverage in force under this provision. The Grace Period will not continue coverage beyond a date stated in the Termination provision.

CONVERSION PRIVILEGE

APPLICABLE TO ALL PLANS

If a Covered Person's coverage under the Policy terminates because the Policy is cancelled and not replaced by another group policy, he or she will have the right to request conversion without giving medical evidence of insurability.

The Covered Person must:

a) make written application for conversion; and
b) pay the initial premium;

within 31 days after he or she ceases to be covered under the Policy.

The conversion policy:

a) will have the provisions, limitations and exclusions on the form we are issuing for this purpose at the time of conversion;
b) will base premiums on our rates in effect for new applicants of the Covered Person's Age, sex and geographic location at the time of conversion.

The Covered Person will be given a choice to elect conversion coverage which:

a) provides similar benefits to the Senior Medical Insurance Plan he or she had under the Policy; or
b) provides the minimum benefits required by law for a Medicare Supplement policy.

Conversion coverage issued to the Covered Person under the Conversion Privilege becomes effective on the date of his or her termination and will be in lieu of all other benefits under the Policy.

SENIOR MEDICAL INSURANCE PLAN BENEFITS

HOSPITAL CONFINEMENT BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

When a Covered Person is covered under this Benefit and is Confined in a Hospital, we will pay the benefit stated below. The Confinement must be a Medicare Approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 60th Day of Hospital Confinement: For the first 60 Days of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except the Medicare Part A Deductible.

We cover the Medicare Part A Deductible if it is indicated on the Covered Person's Schedule of Benefits and Amounts.

61st to 90th Day of Hospital Confinement: From the 61st to 90th Day of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except a daily Coinsurance Charge equal to 25% of the Medicare Part A Deductible.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the Medicare Part A Coinsurance Charges the Covered Person Incurs from the 61st to 90th Day of Confinement.

Lifetime Reserve Period: Regular Medicare Hospital benefits end on the 90th Day of Confinement during a Medicare Part A Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If he or she uses the days, Medicare pays all Hospital Expenses Incurred during the Lifetime Reserve Period except a daily Coinsurance Charge equal to 50% of the Medicare Part A Deductible.

We pay the Medicare Part A Coinsurance Charges during the Lifetime Reserve Period. If the Covered Person saves the days for future use, we limit our daily payment to 50% of the Medicare Part A Deductible.

After the Lifetime Reserve Period: After the Lifetime Reserve Period ends (or would have ended if used), we will pay the percentage shown on Your Schedule of Benefits and Amounts of Hospital Expenses Incurred for each Day of Confinement during a Medicare Part A Benefit Period. Our payment period will be limited to an additional 365 Days of Confinement per person per lifetime.

SENIOR MEDICAL INSURANCE PLAN BENEFITS (Continued)

SKILLED NURSING FACILITY BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

When a Covered Person is covered for this Benefit and Confined in a Skilled Nursing Facility, we will pay the benefit stated below. The Confinement must be a Medicare Approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 20th Day of Skilled Nursing Facility Confinement: For the first 20 Days of Approved Confinement during a Medicare Part A Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses.

We pay nothing from the 1st to 20th Day of Confinement.

21st to 100th Day of Skilled Nursing Facility Confinement: From the 21st to 100th Day of Approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Skilled Nursing Facility Expenses except a daily Coinsurance Charge equal to 12 1/2% of the Medicare Part A Deductible.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the Medicare Part A Coinsurance Charges the Covered Person Incurs from the 21st to 100th Day of Confinement.

EXTENDED SKILLED NURSING FACILITY BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

101st to 365th Day of Skilled Nursing Facility Confinement: After the 100th Day of Confinement during a Medicare Part A Benefit Period, Medicare benefits for Skilled Nursing Facility Confinements end. If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the lesser of:

a) the daily amount stated in the Schedule; or
b) the room and board expense Incurred;

from the 101st to the 365th Day of Confinement.

Medicare Approved Confinement: Medicare only approves Skilled Nursing Facility Confinement that provides skilled, medically necessary care:

a) at a level meeting Medicare standards; and
b) commencing within 30 days of discharge from a Hospital Confinement of at least 3 consecutive days.

Our benefit under this plan is limited to those Days of Confinement which Medicare approves, or would have approved had Medicare benefits for the Confinement not been exhausted.

SENIOR MEDICAL INSURANCE PLAN BENEFITS (Continued)

MEDICAL CARE BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

After the Medicare Part B Deductible, Medicare pays the percentage shown in Your Schedule of Benefits and Amounts of Medicare Part B Eligible Expenses. The portion of an expense which is more than Medicare considers reasonable:

a) is not a Medicare Part B Eligible Expense;
b) is not covered by Medicare; and
c) is not covered under this benefit.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We will pay the percentage shown in Your Schedule of Benefits and Amounts of the Medicare Part B Eligible Expenses after the Medicare Part B Deductible is met each Calendar Year. The expenses must be Incurred by a Covered Person while covered by this benefit. Expenses applied toward the Medicare Part B Deductible are not covered under this benefit.

MEDICARE PART B EXCESS CHARGES BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay a percentage of the difference between:

a) the actual Medicare Part B charge as billed; and
b) the Medicare approved Part B charge;

after the Medicare Part B Deductible is met each Calendar Year. However, our payment will not exceed any charge limitation established by Medicare or state law. The expenses must be Incurred by a Covered Person while covered under this benefit.

We will not pay this benefit if:

a) the provider of the Medical Care accepts Medicare assignment; or
b) the service or supply is not covered by Medicare Part B.

The Out-of Pocket Expense Amount is:

a) stated in the Schedule of Benefits and Amounts; and
b) applies to each Covered Person each Calendar Year.

Only Out-of-Pocket Expenses can be used to meet the Out-of-Pocket Expense Amount.

Out-of-Pocket Expenses means:

a) the portion of any expense, covered under Medicare Part B, which is more than Medicare considers reasonable, up to the Usual and Customary Charge; plus
b) expenses used to meet the Medicare Part B Deductible to the extent the Medicare Part B Deductible is not covered under the Policy.

Out-of-Pocket Expenses do not include expenses that are excluded or limited under the Policy.

Expenses Incurred During Last 3 Months of a Calendar Year: If:

a) a Covered Person Incurs Out-of-Pocket Expenses during the last 3 months of a Calendar Year; and
b) those expenses are applied to his or her Out-of-Pocket Expense Amount during the Calendar Year;

then, a Covered Person's Out-of-Pocket Expense Amount for the next Calendar Year will be reduced by the amount of those expenses. If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, the percentage payable will be stated in the Schedule.

PRIVATE DUTY NURSING BENEFIT
During Hospital Confinement

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the lesser of:

a) the expense Incurred; or
b) the Private Duty Nursing Maximum Benefit Amount;

for each shift of private duty nursing service, up to the Maximum Number of Shifts per Calendar Year.

The private duty nursing service must be provided to a person while he or she is:

a) covered under this benefit; and
b) Confined in a Hospital.

The private duty nursing services must be charged directly to a Covered Person by the Nurse and not charged by the Hospital.

Nurse means:

a) a Registered Graduate Nurse (R.N.); or
b) a Licensed Practical Nurse (L.P.N.);

who is not a member of a Covered Person's Family.

Family means a Covered Person's:

a) children, parents, spouse, brother or sister; or
b) Spouse's children, parents, brother, or sister.

We will not pay for more than 3 shifts of private duty nursing services per day. A shift consists of at least 3 consecutive hours of nursing care. Shifts of more than 3 hours but less than 8 hours will be paid on a pro-rata basis.

The Maximum Benefit Amount and the Maximum Number of Shifts are stated in the Schedule, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

MEDICARE PART B DEDUCTIBLE BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the Medicare Part B Eligible Expenses incurred by a Covered Person used to satisfy the Medicare Part B Deductible each Calendar Year.

The Medicare Part B Eligible Expenses must be incurred by a Covered Person while he or she is covered under this benefit.

SENIOR MEDICAL INSURANCE PLAN BENEFITS (Continued)

FOREIGN TRAVEL EMERGENCY BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

Foreign Travel Emergency Benefit: We will pay a percentage of the expenses Incurred by a Covered Person for Foreign Travel Emergency Medical Treatment if:

a) the Covered Person has satisfied the Calendar Year Deductible; and
b) the first expense was Incurred within the first 60 days of travel Outside of the United States.

Payment under this benefit will be limited to the Lifetime Maximum Benefit Amount.

The Percentage Payable, Deductible Amount and Lifetime Maximum Benefit Amount are shown in the Schedule of Benefits and Amounts if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

This benefit will not cover Foreign Travel Emergency Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Travel Emergency Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the United States for 6 consecutive months or longer.

In addition, this benefit will not cover Foreign Travel Emergency Medical Treatment if Medicare approves the treatment (in which event, the other benefits of the Plan apply).

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Foreign Travel Emergency Medical Benefit.

Foreign Travel Emergency Medical Treatment means any medically necessary Confinement, service, or supply needed immediately due to an Injury or Sickness of sudden and unexpected onset while the Covered Person is Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and American Samoa.

SENIOR MEDICAL INSURANCE PLAN BENEFITS (Continued)

FOREIGN MEDICAL TREATMENT BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

Foreign Medical Treatment Benefit: We will pay the reasonable expense Incurred by a Covered Person for Foreign Medical Treatment provided he or she receives the first Foreign Medical Treatment:

a) while covered by this benefit; and
b) within the first 180 days of travel Outside of the United States per Calendar Year.

This benefit will be limited to treatment received during a Foreign Medical Treatment Benefit period. The Foreign Medical Treatment Benefit Period:

a) begins on the date of the first Foreign Medical Treatment; and
b) ends 90 consecutive days later.

This benefit will not cover any part of a Confinement that extends beyond that 90 day benefit period or any service or supply received after that 90 day benefit period.

This benefit will not cover Foreign Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the Untied States for 6 consecutive months or longer.

In addition, this benefit will not cover Foreign Medical Treatment if Medicare approves the treatment (in which event, the regular benefits of the Senior Medical Insurance Plan Benefits apply).

However, if:

a) a Covered Person must remain Outside of the United States more than 6 months because of an Injury or Sickness that prevents return to the United States; and
b) he or she has established a Foreign Medical Treatment Benefit Period for that Sickness or Injury within the first 180 days of travel, as stated above;

then, we will continue this benefit for that Sickness or Injury until the end of the Foreign Medical Treatment Benefit Period.

Foreign Medical Treatment means any medically necessary Confinement, service or supply received Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and America Samoa.

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Foreign Medical Treatment Benefit.

AT HOME RECOVERY BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

If a Covered Person's Physician certifies that the Covered Person requires the services of a Care Provider for Home recovery from a Sickness, Injury or surgery for which a Home Care Plan of Treatment was approved by Medicare, then if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, we will pay the lesser of:

a) the expense Incurred; or
b) the At-Home Recovery Maximum Amount per visit;

for short term At-Home Recovery Visits, up to the Maximum Benefit Amount per Calendar Year.

The At-Home Recovery Visits must be:

a) provided to a person while he or she is covered under this benefit;
b) primarily to provide services which assist in Activities of Daily Living;
c) provided on a visiting basis in the Covered Person's Home; and
d) provided while the Covered Person is receiving Medicare-approved home care services or within 8 weeks after the service date of the last Medicare home health care visit.

The Covered Person's attending Physician must certify that the specific type and frequency of At-Home Recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare. This benefit will not pay for:

a) At-Home Recovery Visits paid for by Medicare or other government programs;
b) At-Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers, as defined;
c) more than the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment; or
d) more than 7 visits in any one week.

The Maximum Amount per visit, the Maximum visits per week and the Maximum Benefit Amount are shown in the Schedule of Benefits and Amounts if You are covered for this Benefit.

Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

At-Home Recovery Visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a care provider is considered one visit.

Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

AT HOME RECOVERY BENEFIT (Continued)

Home means a place used by the Covered Person as a place of residence. It may be the Covered Person's own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution, provided that such a place would qualify as a residence for Home Health Care services covered by Medicare. A Hospital or Skilled Nursing Facility is not considered the Covered Person's home.

PREVENTIVE MEDICAL CARE BENEFIT

Note: The Schedule of Benefits and Amounts will indicate the Benefits applicable to each Covered Person while covered under the Policy.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the actual charges up to the Medicare approved amount for expenses Incurred by the Covered Person for:

a) an annual clinical preventive medical history and physical examination (which may include Preventive Screening Tests or Services) and patient education to address preventive health measures; and
b) Preventive Screening Tests and Services, as defined; and
c) influenza vaccine administered at any appropriate time during the year; and
d) Tetanus and Diphtheria booster every 10 years; and
e) any other tests or preventive measures determined to be appropriate by the attending Physician.

The expenses must be Incurred by a Covered Person while covered by this benefit.

Our payment will be limited to the Maximum Benefit Amount per Calendar Year shown in the Schedule of Benefits and Amounts, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

Preventive Screening Tests and Preventive Services means one or more of the following, the frequency of which is considered medically appropriate:

a) fecal occult blood test and/or digital rectal examination;
b) mammogram;
c) dipstick urinalysis for hematuria, bacteriuria and proteinauria;
d) pure tone (air only) hearing screening tests, administered or ordered by a physician;
e) serum cholesterol screening (every 5 years);
f) thyroid function test; and
g) diabetes screening.

HOSPICE CARE BENEFIT

APPLICABLE TO ALL PLANS

Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except coinsurance charges for Inpatient respite care, drugs and biologicals.

When a Covered Person elects to receive Hospice Care, we will pay the Medicare Coinsurance Charges which he or she Incurs.

The Hospice Care must:

a) be approved by Medicare; and
b) be received while covered by this benefit.

When this benefit is payable, no other benefits of the Policy will be provided for any expense which is covered under this Hospice Care Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

STATE MANDATED BENEFITS

With respects to insureds of the following states, the following benefits are added to the Policy and Certificate:

California:

Cancer Screenings Benefit

We will pay the Usual and Customary charges not covered by Medicare for mammography and cervical cancer screenings Incurred by a Covered Person each Calendar Year.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

BLOOD DEDUCTIBLE BENEFIT
APPLICABLE TO ALL PLANS

Medicare does not cover the first 3 pints of blood received under Medicare Part A or Medicare Part B each Calendar Year.

We pay the expenses a Covered Person Incurs for these first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations:

a) under Medicare Part A, except to the extent benefits for the Part B Blood Deductible have been paid; or
b) under Medicare Part B, except to the extent benefits for the Part A Blood Deductible have been paid.

The expenses must be Incurred while a Covered Person is covered by this benefit.

EXTENSION OF BENEFITS
APPLICABLE TO ALL PLANS

If a Covered Person is Totally Disabled on the date his or her coverage terminates, we will extend the Policy Benefit Period for expenses Incurred as the result of that disability, subject to all Policy benefit provisions, exclusions, and limitations.

For Medicare Part A Eligible Expenses: A Policy Benefit Period for Medicare Part A Eligible Expenses which is established prior to termination extends until the first to occur of:

a) the date the Covered Person has not been Confined in a Hospital or Skilled Nursing Facility for a period of 60 consecutive days; or
b) the 365th day after termination.

If a Covered Person's coverage terminates while he or she is receiving approved Hospice Care, the Hospice Care benefits of the Policy will continue until the end of the Hospice Care benefit period, as defined by Medicare.

For Medicare Part B Eligible Expenses: The Policy Benefit Period for Medicare Part B Eligible Expenses extends until the end of the Calendar Year quarter following termination as shown below:

Termination Month	**Extension Date**
January, February, March	June 30 of same year
April, May, June	September 30 of same year
July, August, September	December 31 of same year
October, November, December	March 31 of next year.

GENERAL LIMITATIONS
APPLICABLE TO ALL PLANS

Limitation: If a Covered Person has not enrolled in both Medicare Part A and Part B, we will pay the benefits under the Policy as if he or she had enrolled in both parts of Medicare.

SENIOR MEDICAL INSURANCE PLAN ADDITIONAL BENEFITS (Continued)

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

PRE-EXISTING CONDITION LIMITATION
APPLICABLE TO ALL PLANS

Pre-existing Condition means any Injury or Sickness for which a Covered Person received medical advice or treatment within the 6 month period immediately before:

a) his or her effective date of coverage; or
b) the effective date of an increase in coverage;

whichever is applicable.

Conditions Prior to Effective Date: During the first 6 months from a Covered Person's effective date of insurance, expenses Incurred for Pre-existing Conditions are not covered.

Change from a Related Policy: If a Covered Person's coverage has converted without interruption:

a) from the Related Policy;
b) to this Policy;

we will credit toward satisfaction of the above Pre-Existing Condition Limitation the period that he or she was continuously covered by the Related Policy immediately before the conversion.

Any expenses Incurred which are payable under an Extension of Benefits provision of the Related Policy will not be payable under this Policy.

Replacement Coverage: If the Covered Person:

a) has purchased coverage under this Policy in order to replace coverage under a prior Medicare Supplement policy or Senior Medical Insurance Plan; and
b) he or she provides proof of coverage under such prior Senior Medical Insurance Plan policy;

we will credit toward satisfaction of this Policy's Pre-existing Condition Limitation the period that he or she was continuously covered by the prior Medicare Supplement or Senior Medical Insurance Plan policy immediately before his or her effective date under this Policy.

However, if benefits under this Policy are greater than those provided by the prior policy, the 6 month Pre-existing Condition Limitation of this Policy will apply only to the increased benefits.

Conditions Prior to Effective Date of Increase in Coverage: During the first 6 months following the date a Covered Person makes a change in coverage that increases benefits, the increased portion of the benefit will not be payable for expenses Incurred due to Pre-existing Conditions.

This Limitation will not apply to any increase in coverage due to changes in Medicare benefits.

GENERAL EXCLUSIONS
APPLICABLE TO ALL PLANS

The Policy does not cover:

1. any expense that is:
    a) not a Medicare Eligible Expense; or
    b) beyond the limits imposed by Medicare for such expense; or
    c) excluded by name or specific description by Medicare;

   except as specifically provided under the Policy;
2. any portion of a covered expense to the extent paid by Medicare;
1. any benefits payable under one benefit of the Policy to the extent payable under another benefit of the Policy; and
4. covered expenses Incurred after coverage terminates except as stated in the Extension of Benefits provision.

CLAIM PROVISIONS
APPLICABLE TO ALL PLANS

Notice of Claim: The person who has the right to claim benefits must give us written notice of a claim within 20 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice should include your name and the Policy number. Send it to the Hartford's approved Claims Administrator.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim. If the forms are not received, the claimant will satisfy the proof of loss requirement if written proof of the occurrence, character and extent of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

a) the end of each month of our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any benefit due:

a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefits due and not assigned, to you, if living. Otherwise, we will pay:

a) any benefits due for a loss which occurred prior to your death to your estate;
b) any benefits due to a Covered Dependent's loss to the Dependent.

If a benefit due is payable to a minor, it will be paid to his or her guardian. If a benefit due is payable to your Dependent and he or she dies, it will be paid to the Dependent's estate. If a benefit due is payable to:

a) the Dependent's estate;
b) to a minor; or
c) to a person not competent to give valid release for payment;

we may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to you by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

CLAIM PROVISIONS (Continued)

If you provide us with a Written Release to do so, we may, at our option, pay benefits directly to the institution or person rendering:

a) Hospital services; or
b) nursing, medical, or surgical services;

unless you or the person to whom the benefit is payable requests otherwise in writing no later than the time the proof of loss is filed with us.

Written Release means any written direction from you to pay benefits to the institution or person rendering the service. We will not require that the services be rendered by a particular institution or person.

Assignment: You may assign the benefits of the Policy to the institution, or person rendering service as allowed in the Payment of Claims provision. You may not assign the Policy in any other way or to any other person.

Physical Examinations: While a claim is pending we have the right at our expense to have the person who has a loss examined by a Physician when and as often as we feel is necessary.

Legal Actions: Legal action cannot be taken against us:

a) before 60 days following the date proof of loss is sent to us;
b) after 3 years following the date proof of loss is due.

Changes to Medicare: Benefits are adjusted annually to reflect changes in the federal government's Medicare program. These changes may cause increases or decreases in benefit amounts payable under the Policy.

The amount of Medicare Eligible Expenses covered as the result of an increase in our benefits cannot be used to satisfy any deductible under the Senior Medical Insurance Plan Benefits.

However, this increase in benefits due to a reduction in Medicare payments will not apply if the provider accepts Medicare Assignment for the Medical Care.

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

will pay benefits according to the conditions of this Policy.
Signed for the Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

THE HARTFORD GROUP RETIREE INSURANCE POLICY (SM)

NOTICE TO BUYER: This Policy may not cover all of the costs associated with medical treatment and services provided to the buyer during the period of coverage. The buyer is advised to review carefully all Policy limitations.

This is not a standardized Medicare Supplement Plan.

This is a Supplemental Policy only.

Policyholder Name: County of Fresno

Policy Number: AGP-3829

Policyholder Address: 2200 Tulare Street, Suite 1400
Fresno, CA 93721

Policy Effective Date: January 1, 2011

Policy Renewal Date: January 1/1/17 – 12/31/17 unless mutually agreed upon between the Policyholder and Us.

RENEWABILITY: Except for material misrepresentation, coverage under this Policy will continue by timely payment of premium until the first to occur of:

a) the date the Policy is cancelled; or
b) the date the Covered Person ceases to qualify within a class of persons eligible for coverage under this Policy.

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Accepted by

Policyholder

Countersigned by

Licensed Resident Agent

SCHEDULE – ELIGIBILITY

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THIS POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THIS POLICY.

Eligible Person: Eligible Persons are described below.

Class	Description of Eligible Persons
1	All Retirees Employees of the Policyholder who are entitled to Medicare.
2	All Retirees who are covered under this Policyholder's group health plan and who are under age 65. Retirees in this class are not eligible for coverage under this policy but may enroll their Eligible Dependents
3	widow/widowers of a deceased spouse who was an active employee or Retiree of the Policyholder and who is entitled to Medicare.

Eligible Dependents: Class 1 and Class 2 Eligible Persons may apply for Dependent's Coverage. Eligible Dependents are described below:

Description of Eligible Spouse

The Eligible Person's Spouse who is entitled to Medicare, provided the spouse is not legally separated or divorced from the Eligible Person.

Spouse will include the Eligible Person's domestic partner, provided he or she has executed a Domestic Partner Affidavit satisfactory to Us, establishing that the Eligible Person and his or her partner are domestic partners for purposes of this Policy. The Eligible Person and such domestic partner will continue to be considered domestic partners provided they continue to meet the requirements described in the Domestic Partner Affidavit.

Eligibility Restrictions: The Eligible Person must enroll for coverage under either this Policy or the Related Policy in order to enroll for Dependent's Coverage.

If a husband and wife are both Eligible Persons, only one may apply for Insured Person Coverage with the other covered as a Dependent only. A Dependent's Plan Benefits must be the same as, or less than, the Eligible Person's Benefit Plan. However, this limitation will not apply if the Eligible Person is covered by the Related Policy.

In no event will a person be eligible for coverage under this Policy if he or she:

a) is engaged in active employment or is the Dependent of a person engaged in active employment, and is covered by an employer's health plan which is primary payor to Medicare; or
b) is covered by Medicaid; or
c) has other coverage in force that supplements Medicare or which provides coverage for his or her hospital or medical expense; or
d) is not covered by Medicare.

Enrollment Period: Each Eligible Person must enroll for coverage under this Policy during an enrollment period.

The initial enrollment period will be a 30 consecutive day period, established by mutual agreement with the Policyholder. We may establish later periods of open enrollment by mutual agreement with the Policyholder, but not more often than once in a 12 month period.

Persons who become eligible for coverage after the enrollment period must enroll for coverage during the 30 consecutive days following the date they first become Eligible Persons.

SCHEDULE - BENEFITS AND AMOUNTS

THE SCHEDULE OF BENEFITS SHOWS THE BENEFITS FOR WHICH THE ELIGIBLE PERSON(S) ARE COVERED. THIS POLICY MAY DESCRIBE BENEFITS NOT INCLUDED IN ALL PLANS. PLEASE CHECK THE SCHEDULE OF BENEFITS TO DETERMINE SPECIFIC COVERAGE UNDER THIS POLICY.

Benefits and Amounts: A Covered Person's plan will be the one plan that the Eligible Person elected from the Schedule as shown below and on the following page(s). The election must be in accordance with the Eligibility provisions and all other terms of this Policy.

PLAN BENEFITS

BENEFIT	AMOUNT PAYABLE
Hospital Confinement Benefit Day of Confinement 1st to 60th Day	100% of the Medicare Part A Deductible
61st to 90th Day	100% of the Medicare Part A Coinsurance charge per day (Coinsurance charge is equal to 25% of Medicare Part A Deductible)
91st – 150th Days (Lifetime Reserve Period)	100% of the Medicare Part A Coinsurance charge per day (Coinsurance charge is equal to 50% of Medicare Part A Deductible)
After Lifetime Reserve Period	100% of Hospital Expenses Incurred for each Day of Confinement for an additional 365 Days of Confinement per lifetime
Skilled Nursing Facility Benefit Day of Confinement 21st to 100th Day	100% of the Medicare Part A Coinsurance charge (Coinsurance charge is equal to 12½ % of Medicare Part A Deductible)
Outpatient Medical Expenses per Calendar Year Medicare Part B Deductible Benefit	100% of Medicare Part B Deductible
Medical Care Coinsurance (20% Medicare Part B Eligible Expenses)	100% of Medicare Part B 20% Coinsurance

SCHEDULE - BENEFITS AND AMOUNTS (Continued)

Additional Plan Benefits

BENEFIT	AMOUNT PAYABLE
Foreign Travel Emergency	80% of the Foreign Travel Emergency Medical Treatment Expense Deductible Amount: $250 Lifetime Maximum Benefit Amount: $50,000
Outpatient Medical Care Excess	100% of the difference between the actual Medicare Part B charge as billed and the Medicare approved Part B charge.
Hospice Care Benefit	The coinsurance for Inpatient respite care, drugs, and biologicals for all Medicare approved Hospice charges
Blood Deductible Benefit	First 3 pints of blood under Medicare Part A and Medicare Part B
State Situs Mandate Benefits	See Benefits in the GRIP All State Rider PA-9243

SCHEDULE – PREMIUMS

Individual Premiums: Premiums for each Covered Person are stated below.

The premiums stated in this section are for monthly periods of coverage. Semi-annual premiums are 6 times and annual premiums are 12 times those stated. If a premium becomes due for a different period of time, it will be determined pro rata.

Individual Plan Benefit Monthly Premiums

$239.95

*A $13.95 per person per month administrative fee for services which include but are not limited to billing, enrollment, claims payment and customer service is included in the per person per month premium.

Covered Person Premium Due Dates: The first premium for each Covered Person is due on the date he or she becomes covered under this Policy. Each Premium after the initial premium is due at the end of the period for which his or her preceding premium was paid.

Grace Period: After the initial premium, a grace period of 31 days from the Covered Person's Premium Due Date is allowed each Insured Person for payment of each premium due after his or her initial premium. A Covered Person's coverage will be continued during the grace period. If he or she Incurs a covered loss during the grace period, the Insured Person will be liable to Us for payment of any premium accruing during the period We continued coverage in force under this provision. The grace period will not continue coverage beyond a date stated in a Termination provision.

Policy Premium: The premium for this Policy is the sum of Individual Premiums for each Covered Person.

Policy Premium Due Dates: This Policy Premium is payable on:

a) the Policy Effective Date; and
b) the 1st day of each month thereafter, with respect to each Covered Person whose premium becomes due on such date, subject to the Grace Period provision.

Each Policy Premium is due on or in advance of the date it becomes payable. This Policy terminates on the last day of the period for which premium is paid, subject to the grace period.

Policy Premium Payment: The Policy Premiums are to be paid to Us by the Policyholder. However, they may be paid to Us by any other person according to a mutual agreement among the other person, the Policyholder and Us.

Change of Policy Premiums: We have the right on any premium due date to change the rate at which future premiums will be calculated. This includes the right to change premium rates for a benefit that applies to all individuals of the same class and geographic location.

Rates may be changed based on:

a) changes in Medicare;
b) the claims experience of this Policy;
c) state or federal legislation affecting health insurance coverage with which this Policy must comply; or
d) the experience of all groups on which We write group retiree medical coverage providing similar Plan Benefits.

We will give the Policyholder advance written notice of any change in premium rates at least 30 days prior to the Premium Due Date on which the change is to become effective.

Policyholder Grace Period Provision: A grace period of 31 days is allowed for payment of each premium due after the first unless the Policy is cancelled on or before the due date. This Policy will continue in force during the grace period. The Policyholder is liable to Us for the payment of premium accruing for the period this Policy continues in force.

CONTRACT PROVISIONS

Entire Contract: The entire contract between the Policyholder and Us consists of this Policy and any forms made a part of this Policy at issue.

All statements made by the Policyholder or the Covered Person will be deemed representations and not warranties. No statement made to effect this insurance will:

a) void the insurance; or
b) reduce benefits unless it is in writing and signed by the Policyholder or the Covered Person.

Changes: We reserve the right to make changes in this Policy. We will give the Policyholder 30 days advance written notice of any change.

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made a part of this Policy.

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

Certificates: We will give individual Certificates to:

a) the Policyholder; or
b) any other person according to a mutual agreement among the other person, the Policyholder and Us;

for delivery to each Insured Person.

The Certificates will state the features of this Policy that are important to each Covered Person.

30 Day Right to Examine Certificate: The Insured Person has a 30 day right to examine his or her Certificate. If the Insured Person is not satisfied, he or she may return it to Us within 30 days of the date of its delivery. In that event, We will consider it void from the Certificate effective date and any premium paid will be refunded to either the Policyholder or Insured Person. Any claims paid will be deducted from the refund.

Data Furnished by Policyholder: The Policyholder, or any other person designated by the Policyholder, may keep the important insurance records on all Covered Persons. The Policyholder or its designee must give Us information, when and in the manner We ask, to administer the insurance provided by this Policy.

The Policyholder or designee will, upon Our request, give Us:

a) the names of all persons initially eligible;
b) the name of all additional persons who become eligible;
c) the names of all Covered Persons;
d) the names of all persons whose benefit is to be changed;
e) the names of all persons whose insurance is cancelled; and
f) any data necessary to calculate premiums.

The Policyholder's failure to:

a) give Us the name of any Covered Person will not invalidate such person's insurance; or
b) report a Covered Person's termination of insurance will not continue coverage beyond the date of termination.

The Policyholder's insurance records will be open for Our inspection at any reasonable time.

Clerical Error: Clerical error (whether by the Policyholder, the Third Party Administrator, or Us) in keeping the records having to do with this Policy, or delays in making entries on the records, will not void the insurance of any person if that insurance would otherwise have been in effect. Such clerical error will not extend the insurance of any person if that insurance would otherwise have ended or been reduced as provided by this Policy.

When a clerical error is found, premiums and benefits will be adjusted based on the true facts and this Policy.

Policy Cancellation: Notice of Policy cancellation may be provided at any time by written notice sent by Us to the Policyholder or by the Policyholder to Us. If We cancel, We will deliver the notice to the Policyholder at its last address shown in Our records.

If We cancel, it becomes effective on the later of:

a) the date stated in the notice; or
b) the 31st day after We mail or deliver the notice (60 days in New Jersey).

If the Policyholder cancels, it becomes effective on the later of:

a) the date We receive the notice;
b) the date stated in the notice; or
c) the 31st day after the notice is delivered.

In either event:

a) We will promptly return any unearned premium paid; or
b) the Policyholder will promptly pay any earned premium that has not been paid.

Any earned or unearned premium will be determined on a pro rata basis.

Cancellation will be without prejudice to any claim that originated prior to the effective date of the cancellation.

Not in Lieu of Worker's Compensation: This Policy does not satisfy any requirement for worker's compensation insurance.

Conformity with Law: If any provision of this Policy is contrary to the law of the jurisdiction in which it is delivered, such provision is hereby amended to conform to that law.

INCORPORATION PROVISION

The Certificate(s) of Insurance and Riders listed below are attached to, incorporated in and made a part of this Policy.

Certificate of Insurance	Applicable to:	Effective Date of Incorporation
GBD-1500 CRT	All Eligible Persons	January 1, 2011

The provisions listed below are shown in the Certificate(s) of Insurance and are hereby incorporated into and made a part of this Policy.

General Definitions
Insured Person Period of Coverage
Covered Dependent Period of Coverage
Conversion Privilege
Benefits
State Mandates and Exceptions Provision
Eligibility for Payment of Benefits
Extension of Benefits
General Limitation
Pre-existing Conditions Limitation
General Exclusion
Claims Provisions
Riders (if any)

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A STANDARDIZED MEDICARE SUPPLEMENT PLAN.

THE HARTFORD GROUP RETIREE INSURANCE PLAN (sm)
CERTIFICATE OF PLAN BENEFITS

Hartford Life and Accident Insurance Company
Hartford, Connecticut

Policyholder Name: County of Fresno

Policy Number: AGP-3829

30 Day Right to Examine Certificate: We urge you to examine this Certificate closely. If you are not satisfied, return it to Us within 30 days of the date of its delivery. In that event, We will consider it void from the Certificate effective date and any premium paid will be refunded to the Policyholder. Any claims paid will be deducted from the refund.

Notice to buyer: The Policy may not cover all of the costs associated with medical care Incurred by you during the period of coverage. You are advised to review carefully all Policy limitations contained in this certificate.

RENEWABILITY: Except for material misrepresentation, coverage under the Policy will continue by timely payment of premium until the first to occur of:

a) the date the Policy is cancelled; or
b) the date the you or your dependents cease to qualify within a class of persons eligible for coverage under the Policy.

We have issued a Policy to the Policyholder. The provisions of the Policy which are important to you are summarized in this Certificate; consisting of this form, the Schedule of Benefits and Amounts with the most recent effective date and any additional forms which have been made a part of this Certificate. This Certificate replaces any certificates that may have been given to you earlier for 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. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

Form GBD-1500 CRT A.1

YOUR SCHEDULE OF BENEFITS AND AMOUNTS SHOWS THE BENEFITS FOR WHICH YOU AND/ OR YOUR COVERED DEPENDENT ARE COVERED. THIS CERTIFICATE MAY DESCRIBE BENEFITS NOT INCLUDED IN YOUR PARTICULAR PLAN. PLEASE CHECK YOUR SCHEDULE OF BENEFITS AND AMOUNTS TO DETERMINE SPECIFIC COVERAGE UNDER THE POLICY.

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GENERAL DEFINITIONS

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Age means a Covered Person's attained age on any premium due date.

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Calendar Year Deductible means the amount of Eligible Expenses that each Covered Person must Incur *before* any benefits are paid by Us during a Calendar Year. Expenses Incurred to satisfy the Medicare Part A Deductible and Coinsurance do not apply to the Calendar Year Deductible. The Calendar Year Deductible is shown in the Schedule of Benefits and Amounts.

Child, Children means Your unmarried children, step children, and legally adopted children who, are primarily dependent on You for support and maintenance and who are entitled to Medicare by reason of disability.

The term Children will also include any other children related to You by blood or marriage or domestic partnership and who:

a) lived with You in a regular parent-child relationship; and
b) were eligible to be claimed as dependents on Your federal income tax return.

Confined, Confines, or **Confinement** means being an Inpatient in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

due to Sickness or Injury.

Covered Person means an Eligible Person or Eligible Dependent while covered under the Policy.

Day of Confinement means a day of Inpatient Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

for which a daily room and board charge is made for a full Day of Confinement.

Hospice Care means Medicare approved medical and support services needed to manage symptoms and relieve the pain of a terminal illness. The services must be provided through a Medicare approved Hospice Care Program. Hospice Care includes but is not limited to:

a) nursing care, therapies, medical supplies and appliances;
b) short-term Inpatient respite care; and
c) Physician, home health aide and counseling services.

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Hospital means an institution which:

a) is approved by Medicare and has agreed to participate in Medicare;
b) operates pursuant to law;
c) primarily and continuously provides medical care and treatment on an Inpatient basis for sick and injured persons at the patient's expense;
d) operates diagnostic and major surgical facilities either:
   1) on its premises; or
   2) in facilities available to the Hospital on a prearranged basis;
   3) operates under the supervision of a staff of Physicians; and
e) provides 24-hour nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof that is used primarily as:

a) a nursing home, convalescent home, or Skilled Nursing Facility;
b) a place for rest, custodial, educational or rehabilitory care;
c) a place for the aged; or
d) a place for alcoholism or drug addiction.

Hospital Expenses means:

a) Medicare Part A Eligible Expenses for treatment provided and billed by the Hospital;
b) after the Lifetime Reserve Period, Hospital Expenses of the kind that would have been covered by Medicare had Medicare Part A Benefits not been exhausted.

Incurred means the date a Covered Person received the particular treatment, service, or supply that gave rise to an expense.

Injury means bodily Injury resulting:

a) directly from an accident; and
b) independently of all other causes;

which occurs while You or Your Dependents are covered under the Policy.

Loss resulting from:

a) Sickness or disease, except a pus-forming infection that occurs through an accidental wound; or
b) medical or surgical treatment of a Sickness or disease;

is not considered as resulting from Injury.

Inpatient means Confinement in:

a) a Hospital; or
b) a Skilled Nursing Facility with respect to Skilled Nursing Facility coverage, if any;

for which a room and board charge is made.

Insured Person means an Eligible Person while he or she is covered by the Policy.

Medical Care means any professional or outpatient treatment, service, or supply that is covered by Medicare Part B.

Medicare means Title XVIII of the Social Security Act of 1965, as amended.

Medicare Eligible Expenses means health care expenses covered by Medicare to the extent recognized as reasonable by Medicare.

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Medicare Part A Benefit Period means a period of time during which a Medicare beneficiary is Hospital or Skilled Nursing Facility Confined. A Medicare Part A Benefit Period:

a) begins when a Medicare beneficiary is admitted to a Hospital as an Inpatient; and
b) ends when he or she has not been Confined in a Hospital or Skilled Nursing Facility for 60 consecutive days.

Medicare Part A Deductible means the deductible amount that a Covered Person is required to pay under Medicare for the expenses Incurred at the beginning of a Medicare Part A Benefit Period.

Medicare Part B Deductible means the deductible amount that a Covered Person is required to pay under Medicare Part B each Calendar Year for Medicare Eligible Expenses.

Mental and Nervous Disorders means any neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Physician means a person who is:

a) a doctor of medicine, osteopathy, psychology, or other legally qualified practitioner of a healing arts that We recognize or are required to recognize;
b) licensed to practice in the jurisdiction where care is being given;
c) practicing within the scope of that license; and
d) not related to an Insured Person by blood or marriage or a domestic partner of a Covered Person.

Policy Benefit Period for Medicare Part A Eligible Expenses means a Medicare Part A Benefit Period as defined, but does not include:

a) any Day of Confinement before the Covered Person's effective date; or
b) any Day of Confinement after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

Policy Benefit Period for Medicare Part B Eligible Expenses means a Calendar Year, but does not include any period of time:

a) before the Covered Person's effective date; or
b) after the Covered Person's termination date, except as stated in the Extension of Benefits provision.

Related Policy means the Policyholder's Employee Health Plan.

Request means written request made on the forms We furnish for making the request.

Retiree means a former employee of the Policyholder: a) who is participating in an Employer-sponsored pension plan.

NOT ALL DEFINITIONS ARE APPLICABLE TO A COVERED PERSON'S COVERAGE UNDER THE POLICY. PLEASE CHECK THE SCHEDULE OF BENEFITS.

Sickness means a person's sickness or disease. However, sickness first manifested before a Covered Person's effective date will be subject to the Policy's Pre-existing Condition Limitation.

Skilled Nursing Facility means an institution that:

a) operates pursuant to law;
b) in addition to room and board accommodations, is primarily engaged in providing skilled nursing care under the supervision of a Physician;
c) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate nurse (R.N.); and
d) maintains a daily medical record of each patient.

Skilled Nursing Facility does not mean any institution or part thereof that is used mainly as a home or place:

a) for the aged, or for rest, custodial or educational care;
b) for alcoholism and drug addiction;
c) for the treatment of Mental and Nervous Disorders.

Skilled Nursing Facility Expenses means Medicare Part A Eligible Expenses for services provided and billed by a Skilled Nursing Facility.

Spouse means Your wife or husband who was not legally separated or divorced from You. Spouse will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to Us, establishing the You and Your partner are domestic partners for purposes of the Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.

Totally Disabled means:

a) disabled by an Injury or Sickness that continuously Confines a Covered Person in a Hospital or Skilled Nursing Facility; or
b) if not Confined, continuously disabled by an Injury or Sickness which a Covered Person's Physician certifies prevents him or her from engaging in the normal activities of a person of like age and gender in good health.

Usual and Customary Charge means the prevailing charge made by most providers of a given service in the geographic area where the service is received. In no event will the Usual and Customary Charge exceed the actual amount charged.

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

INSURED PERSON PERIOD OF COVERAGE

Insured Person Effective Date: An Eligible Person will become covered by the Policy on the later to occur of:

a) the Policy Effective Date, if he or she enrolled prior to the Policy Effective Date; or
b) the Policy Effective Date if We receive his or her Request for coverage prior to the Policy Effective Date; or
c) the first day of the month on or next following the date he or she becomes an Eligible Person; or
d) the first day of the month after We receive the Request, if it is received at any other time; or
e) with respect to an Eligible Person who attained Age 65 while covered by the Related Policy, the date stated in that Policy's Conversion provision;

subject to payment of the required premium.

Request for Change in Insured Person's Coverage (if available under this Policy): If the Insured Person Requests to make a change in coverage, the change will become effective on the first day of the month after We receive the Request provided:

a) the Insured Person is eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the Pre-existing Condition Limitation provision.

Insured Person Termination: The Insured Person's coverage under the Policy will cease on the first to occur of:

a) the date the Policy is cancelled; or
b) the premium due date that the required premium for his or her coverage is not paid, subject to the Grace Period provision; or
c)

However if the Insured Person is eligible for coverage under the Policy because he or she is the widow/widower of an active employee of the Policyholder. The Insured Person's coverage will cease on the Premium Due Date on or next following the date he or she remarries.

Grace Period: A grace period of 31 days is allowed for payment of each premium due after the first premium. We will continue the insurance during the grace period. If an Insured Person Incurs a covered loss during the Grace Period, the Policyholder will be liable to Us for payment of any premium accruing during the period We continued coverage in force under the provision. The Grace Period will not continue coverage beyond a date stated in the Insured Person Termination Provision.

COVERED DEPENDENT PERIOD OF COVERAGE

DEPENDENT COVERAGE WILL BE INDICATED ON THE SCHEDULE OF BENEFITS, IF APPLICABLE. IF THE SCHEDULE DOES NOT SHOW AN EFFECTIVE DATE FOR COVERAGE FOR THE DEPENDENT, THEN HE OR SHE IS NOT COVERED UNDER THIS POLICY.

Covered Dependent Effective Date: An Eligible Person's Dependent will become covered by the Policy on:

a) the Policy Effective Date, if We receive the Eligible Person's Request for the Dependent's coverage prior to the Policy Effective Date;
b) the first day of the month after We receive the Eligible Person's Request for the Dependent's coverage if it is received at any other time; or
c) with respect to a Dependent who attained Age 65 while covered by the Related Policy, the date stated in that Policy's Conversion provision;

subject to payment of the required premium.

However, in no event will a Dependent become covered under the Policy:

a) before the date he or she qualifies as an Eligible Dependent; or
b) before the Eligible Person's effective date of coverage under either the Policy or the Related Policy.

Request for Change in Dependent Coverage: If the Insured Person Requests to make a change in Dependent's coverage, the change will become effective on the first day of the month after We receive the Request provided:

a) the Dependent is eligible for the change requested; and
b) the required premium is paid.

If the Request increases coverage, the amount of the increase will be subject to the Pre-existing Condition Limitation provision.

Dependent Termination: Dependent coverage under the Policy will cease on the first to occur of:

a) the date the Policy is cancelled;
b) the Premium Due Date that the required premium for his or her coverage is not paid, subject to the Grace Period provision; or
c) with respect to a Covered Dependent who is an eligible Spouse, the premium due date on or next following the date he or she is Divorced from the Eligible Person, unless continued in accordance with the Spouse Continuation provision.

Spouse Continuation: If a covered spouse is Divorced while covered under the Policy, he or she may continue his or her coverage under the Policy. We must receive the Request and required premium to continue coverage under the Policy within 31 days of the date coverage terminates. Solely for the purpose of continuing the coverage under the Policy, the Spouse will be considered the Insured Person. However, this will not continue the coverage beyond a date the coverage would normally cease under a Dependent Termination provision of the Policy. Any coverage continued by this provision will terminate on the Premium Due Date on or next following the date the Spouse remarries or executes another Domestic Partner Affidavit.

Divorce/Divorced means annulment, dissolution of marriage, or legal separation from the Insured Person.

Covered Dependent Grace Period: A grace period of 31 days is allowed for payment of each premium due after the first. We will continue the insurance during the grace period. If a Covered Dependent Incurs a covered loss during the Grace Period, the Policyholder will be liable to Us for payment of any premium accruing during the period We continued coverage in force under this provision. The grace period will not continue coverage beyond a date stated in the Dependent Termination provision.

PLAN BENEFITS

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

HOSPITAL CONFINEMENT BENEFIT

When a Covered Person is Confined in a Hospital, We will pay the benefits stated below. The Confinement must be a Medicare approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 60th Day of Hospital Confinement: For the first 60 Days of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except for the Medicare Part A Deductible.

If a benefit is indicated as payable for Hospital Confinement on the Schedule of Benefits and Amounts, We will pay a benefit equal to the percentage of the Medicare Part A Deductible and for the specified period of time as shown on such Schedule.

61st to 90th Day of Hospital Confinement: From the 61st to 90th Day of approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Hospital Expenses except a daily Coinsurance Charge equal to 25% of the Medicare Part A Deductible.

If a benefit is indicated as payable for Hospital Confinement on the Schedule of Benefits and Amounts, We will a pay benefit equal to the percentage of the Medicare Part A Coinsurance charge shown on such Schedule.

91st to 150th Day of Hospital Confinement (Lifetime Reserve Period): Regular Medicare Hospital benefits end on the 90th Day of Confinement during a Medicare Part A Benefit Period. After the 90th day, Medicare grants a 60 day Lifetime Reserve Period. These 60 additional days can be used only once in a lifetime. Medicare allows a person the choice of using the days or saving them for the future. If he or she uses the days, Medicare pays all Hospital Expenses Incurred during the Lifetime Reserve Period except a daily Coinsurance Charge equal to 50% of the Medicare Part A Deductible.

If a benefit is indicated as payable for Hospital Confinement on the Schedule of Benefits and Amount, We will pay a benefit equal to the percentage of the Medicare Part A Coinsurance Charge shown on such Schedule.

After the Lifetime Reserve Period: After the Lifetime Reserve Period ends (or would have ended if used), We will pay the percentage shown on the Schedule of Benefits and Amounts for Usual and Customary Hospital Expenses Incurred for each Day of Confinement during a Medicare Part A Benefit Period. Our payment period will be limited to an additional 365 Days of Confinement per person per lifetime.

If a benefit is indicated as payable for Hospital Confinement on the Schedule of Benefits and Amount, We will pay a benefit equal to the percentage of the Hospital Expenses Incurred and for the specified period of time as shown on such Schedule.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

SKILLED NURSING FACILITY BENEFIT

When a Covered Person is Confined in a Skilled Nursing Facility, We will pay the benefit stated below. The Confinement must be a Medicare Approved Confinement. A Covered Person must Incur expenses for the Confinement while he or she is covered by this benefit.

1st to 20th Day of Skilled Nursing Facility Confinement: For the first 20 Days of Medicare Approved Confinement during a Medicare Part A Benefit Period, Medicare Part A pays all Skilled Nursing Facility Expenses.

We pay nothing from the 1st to 20th Day of Confinement.

21st to 100th Day of Skilled Nursing Facility Confinement: From the 21st to 100th Day of Medicare Approved Confinement during a Medicare Part A Benefit Period, Medicare pays all Skilled Nursing Facility Expenses except a daily Coinsurance Charge equal to 12 1/2% of the Medicare Part A Deductible.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We will pay a benefit equal to the percentage of the Medicare Part A Coinsurance Charges that the Covered Person Incurs from the 21st to 100th Day of Confinement as shown in such Schedule.

EXTENDED SKILLED NURSING FACILITY BENEFIT

101st to 365th Day of Skilled Nursing Facility Confinement: After the 100th Day of Confinement in a Skilled Nursing Facility during a Medicare Part A Benefit Period, Medicare benefits for Skilled Nursing Facility Confinements end.

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this portion of the Benefit, We pay the lesser of:

a) the daily amount stated in the Schedule; or
b) the room and board expense Incurred shown in such Schedule;

from the 101st to the 365th Day of Confinement.

Medicare Approved Confinement: Medicare only approves Skilled Nursing Facility Confinement that provides skilled, medically necessary care:

a) at a level meeting Medicare standards; and
b) commencing within 30 days of discharge from a Hospital Confinement of at least 3 consecutive days; and
c) is recommended by the Covered Person's Physician.

Our benefit under this plan is limited to those Days of Confinement that Medicare approves, or would have approved had Medicare benefits for the Confinement not been exhausted.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

OUTPATIENT MEDICAL EXPENSE BENEFIT

Medicare Part B Deductible Portion: If a benefit is indicated as payable for the Medicare Part B Deductible on the Schedule of Benefits and Amount, We will pay a benefit equal to the percentage of the Medicare Part B Deductible shown in the Schedule of Benefits and Amounts.

The portion of an expense that is more than Medicare considers reasonable:

a) is not a Medicare Part B Eligible Expense;
b) is not covered by Medicare; and
c) is not covered under this benefit.

The Expenses must be Incurred by a Covered Person while covered by the benefit.

Medical Care Coinsurance Portion: During a Calendar Year, after the Medicare Part B Deductible is met, Medicare pays 80% of Medicare Part B Eligible Expenses. The Covered Person pays the remaining 20% of the Medicare Eligible Expenses. If a Covered Person's Schedule of Benefits and Amounts indicates coverage for that portion of the Benefit, We will pay a benefit equal to the percentage shown in the Schedule of Benefits and Amounts for the coinsurance amount of Medicare Part B Eligible Expenses.

The balance of the Eligible Expenses after We and Medicare pay are payable by the Covered Person. These are referred to as out-of-pocket expenses. When a Covered Person's out-of-pocket expenses equal the amount shown in the Schedule of Benefits and Amounts, We will pay the 100% of the Medicare Part B Coinsurance amount for a Covered Person he or she must then satisfy the corridor deductible. This amount is shown in the Schedule of Benefits and Amounts and is payable by the Covered Person directly. When the corridor deductible is satisfied, We will then pay 100% of the Medicare Part B Coinsurance amount for a Covered Person.

The portion of an expense that is more than Medicare considers reasonable:

a) is not a Medicare Part B Eligible Expense;
b) is not covered by Medicare; and
c) is not covered under this benefit.

The Expenses must be Incurred by a Covered Person while covered by the benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

OUTPATIENT MEDICAL CARE EXCESS CHARGES BENEFIT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay a percentage of the difference between:

a) the actual Medicare Part B charge as billed; and
b) the Medicare approved Part B charge;

after the Medicare Part B Deductible is met each Calendar Year. However, Our payment will not exceed any charge limit action established by Medicare or state law. The expenses must be Incurred by a Covered Person while covered under this benefit.

However, We will not pay this benefit if:

a) the provider of the Medical Care accepts Medicare assignment; or
b) the service or supply is not covered by Medicare Part B.

The Out-of-Pocket Expense Amount is:

a) stated in the Schedule of Benefits and Amounts; and
b) applies to each Covered Person each Calendar Year.

Only Out-of-Pocket Expenses can be used to meet the Out-of-Pocket Expense Amount.

Out-of-Pocket Expenses means:

a) the portion of an expense, covered under Medicare Part B, which is more than Medicare considers reasonable, up to the Usual and Customary Charge; plus
b) expenses used to meet the Medicare Part B Deductible to the extent the Medicare Part B Deductible is not covered under the Policy.

Out-of-Pocket Expenses do not include expenses that are excluded or limited under the Policy.

Expenses Incurred During Last 3 Months of a Calendar Year: If:

a) a Covered Person Incurs Out-of-Pocket Expenses during the last 3 months of a Calendar Year; and
b) those expenses are applied to his or her Out-of-Pocket Expense Amount during the Calendar Year;

then, a Covered Person's Out-of-Pocket Expense Amount for the next Calendar Year will be reduced by the amount of those expenses.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

FOREIGN MEDICAL TREATMENT BENEFIT

Benefits provided only if shown as covered on the Schedule of Benefits and Amounts.

Foreign Medical Treatment Benefit: We will pay the reasonable expense Incurred by a Covered Person for Foreign Medical Treatment provided he or she receives the first Foreign Medical Treatment:

a) while covered by this benefit; and
b) within the first 180 days of travel Outside of the United States during a Calendar Year.

This benefit will be limited to treatment received during a Foreign Medical Treatment Benefit Period. The Foreign Medical Treatment Benefit Period:

a) begins on the date of the first Foreign Medical Treatment; and
b) ends 90 consecutive days later.

This benefit will not cover any part of a Confinement that extends beyond that 90 day benefit period or any service or supply received after that 90-day benefit period.

This benefit will not cover Foreign Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the United States for more than 180 consecutive days.

In addition, this benefit will not cover Foreign Medical Treatment if Medicare approves the treatment (in which event, the regular benefits of the **Country of Fresno** Insurance Plan Benefits apply).

However, if:

a) a Covered Person must remain Outside of the United States more than 180 days because of an Injury or Sickness that prevents return to the United States; and
b) he or she has established a Foreign Medical Treatment Benefit Period for that Sickness or Injury within the first 180 days of travel, as stated above;

then, We will continue this benefit for that Sickness or Injury until the end of the Foreign Medical Treatment Benefit Period.

Foreign Medical Treatment means any medically necessary Confinement, service or supply received Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare Part A and Part B;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and America Samoa.

When this benefit is payable, no other benefits of the Policy will be provided for any expense that is covered under this Foreign Medical Treatment Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

FOREIGN TRAVEL EMERGENCY MEDICAL TREATMENT BENEFIT

Foreign Travel Emergency Medical Treatment Benefit: We will pay the percentage of the expenses Incurred by a Covered Person for Foreign Travel Emergency Medical Treatment if:

a) the Covered Person has satisfied the Calendar Year Deductible; and
b) the first expense was Incurred within the first 60 days of travel Outside of the United States.

Payment under the benefit will be limited to the Lifetime Maximum Benefit Amount.

The Percentage Payable, Deductible Amount and Lifetime Maximum Benefit Amounts are shown in the Schedule of Benefits and Amounts if a Covered Person's Schedule of Benefits and Amounts indicates coverages for this Benefit.

This benefit will not cover Foreign Travel Emergency Medical Treatment if a Covered Person:

a) leaves the United States primarily to seek Foreign Travel Emergency Medical Treatment for a Sickness or Injury;
b) has no legal obligation to pay for the treatment; or
c) receives the treatment during a Calendar Year in which he or she travels or resides Outside of the United States for 6 consecutive months or longer.

In addition, this benefit will not cover Foreign Travel Emergency Medical Treatment if Medicare approves the treatment (in which event, the other benefits of the Plan apply.)

When this benefit is payable, no other benefits of the Policy will be provided for any expense that is covered under this Foreign Travel Emergency Medical Treatment Benefit.

Foreign Travel Emergency Medical Treatment means any medically necessary Confinement, service, or supply needed immediately due to Injury or Sickness of sudden and unexpected onset while the Covered Person is Outside of the United States provided the same medical treatment, if received in the United States:

a) would be considered reimbursable treatment under Medicare;
b) would be considered in general use and of demonstrated value in the diagnosis and treatment of Sickness or Injury by United States Physicians; and
c) would not be considered in a research or experimental stage by United States Physicians.

Outside of the United States means outside the territorial limits of:

a) the 50 United States and the District of Columbia; and
b) Puerto Rico, the Virgin Islands, Guam and American Samoa.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

PRIVATE DUTY NURSING BENEFIT DURING HOSPITAL CONFINEMENT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the Private Duty Nursing Maximum Benefit for each 8 hour shift. In no event will We pay more than the actual amount charged for such Private Duty Nursing shift nor will We pay more than the maximum number of shifts per Calendar Year.

The private duty nursing service must be provided to a Covered Person while he or she is:

a) covered under this benefit; and
b) Confined in a Hospital.

The private duty nursing services must be charged directly to a Covered Person by the Nurse and not charged by the Hospital.

Nurse means:

a) a Registered Graduate Nurse (R.N. or A.P.R.N); or
b) a Licensed Practical Nurse (L.P.N.);

who is not related to a person by blood or marriage or a domestic partner of a Covered Person.

We will not pay for more than 3 shifts of private duty nursing services per day. A shift consists of at least 3 consecutive hours of nursing care. Shifts of more than 3 hours but less than 8 hours will be paid on a pro-rata basis.

The Maximum Benefit Amount and the Maximum Number of Shifts are stated in the Schedule, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

AT HOME RECOVERY BENEFIT

If a Covered Person's Physician certifies that the Covered Person requires the services of a Care Provider for Home recovery from a Sickness, Injury or surgery for which a Home Care Plan of Treatment was approved by Medicare, and if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, then We will pay the lesser of:

a) the expense Incurred; or
b) the At-Home Recovery Maximum Amount per visit;

for short term At-Home Recovery Visits, up to the Maximum Benefit Amount per Calendar Year.

The At-Home Recovery Visits must be:

a) provided to a person while he or she is covered under this benefit;
b) primarily to provide services which assist in Activities of Daily Living;
c) provided on a visiting basis in the Covered Person's Home; and
d) provided while the Covered Person is receiving Medicare-approved home health care services or within 8 weeks after the service date of the last Medicare home health care visit.

The Covered Person's attending Physician must certify that the specific type and frequency of At-Home Recovery services are necessary because of a condition for which a home health care plan of treatment was approved by Medicare.

This benefit will not pay for:

a) At-Home Recovery Visits paid for by Medicare or other government programs;
b) At-Home Recovery Visits provided by family members, unpaid volunteers or providers who are not Care Providers, as defined;
c) more than the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment; or
d) more than 7 visits in any one week.

The Maximum Amount per visit, the Maximum visits per week and the Maximum Benefit Amount are shown in the Schedule of Benefits and Amounts if the Covered Person is covered for this Benefit.

Activities of Daily Living means those daily activities necessary for a person to perform in order to function independently, including, but not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

At-Home Recovery Visit means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24 hour period of services provided by a Care Provider is considered one visit.

Care Provider means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

Home means a place used by the Covered Person as a place of residence. It may be the Covered Person's own dwelling, an apartment, a relative's home, a home for the aged or some other type of institution, provided that such a place would qualify as a residence for Home Health Care services covered by Medicare. A Hospital or Skilled Nursing Facility is not considered the Covered Person's home.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

PREVENTIVE MEDICAL CARE BENEFIT

If a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit, We will pay the actual charges up to the Medicare approved amount for expenses Incurred by the Covered Person for:

a) an annual clinical preventive medical history and physical examination (which may include Preventive Screening Tests or Services) and patient education to address preventive health measures; and
b) Preventive Screening Tests and Preventive Services, as defined; and
c) influenza vaccine administered at any appropriate time during the year; and
d) Tetanus and Diphtheria booster every 10 years; and
e) any other tests or preventive measures determined to be appropriate by the attending Physician.

The expenses must be Incurred by a Covered Person while covered by this benefit.

Our payment will be limited to the Maximum Benefit Amount per Calendar Year shown in the Schedule of Benefits and Amounts, if a Covered Person's Schedule of Benefits and Amounts indicates coverage for this Benefit.

Preventive Screening Tests and Preventive Services means one or more of the following, the frequency of which is considered medically appropriate:

a) dipstick urinalysis for hematuria, bacteriuria and proteinauria;
b) pure tone (air only) hearing screening tests, administered or ordered by a Physician;
c) serum cholesterol screening (every 5 years);
d) thyroid function test; and
e) diabetes screening.

Subject to all other conditions and limitations of the policy, the following Preventive Screening Tests are covered regardless of whether the Covered Person is covered for other Preventive Medical Care benefits as shown in the Schedule of Benefits and Amounts.

Cancer Screening Benefit

If any of the following tests is not covered by Medicare, We will pay the Usual and Customary charges Incurred by the Covered Person for:

a) one mammography screening each Calendar Year ordered by a Physician;
b) one cervical cancer screening each Calendar Year or more frequently if certified by a Physician that such cervical cancer screening is medically necessary; and
c) one prostate screening each Calendar Year for the early detection of prostate cancer for men over 50 years of age. The screening may be performed by any qualified medical professional, including a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant. The screening must include at least the following tests: a prostate-specific antigen (PSA) blood test and/or a digital rectal examination.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

HOSPICE CARE BENEFIT

Under Medicare, a terminally ill person may elect to receive Hospice Care benefits instead of most regular Medicare Part A and Part B benefits. Then, Medicare pays all approved Hospice Care charges except coinsurance charges for Inpatient respite care, drugs and biologicals.

When a Covered Person elects to receive Hospice Care, We will pay the Medicare Coinsurance Charges that he or she Incurs.

The Hospice Care must:

a) be approved by Medicare; and
b) be received while covered by this benefit.

When this benefit is payable, no other benefits of the Policy will be provided for any expense that is otherwise covered under this Hospice Care benefit.

THE SCHEDULE OF BENEFITS AND AMOUNTS WILL INDICATE THE BENEFITS APPLICABLE TO EACH COVERED PERSON WHILE COVERED UNDER THE POLICY.

BLOOD DEDUCTIBLE BENEFIT

Medicare does not cover the first 3 pints of blood received under Medicare Part A or Medicare Part B each Calendar Year.

We pay the expenses a Covered Person Incurs for these first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations:

a) under Medicare Part A, except to the extent benefits for the Part B Blood Deductible have been paid; or
b) under Medicare Part B, except to the extent benefits for the Part A Blood Deductible have been paid.

The expenses must be Incurred while a Covered Person is covered by this benefit.

ELIGIBILITY FOR PAYMENT OF BENEFITS

We will pay the benefit of the Policy only when the following requirements are met:

a) the expense Incurred is a Medicare Eligible Expense, as defined;
b) if the Covered Person is Confined in a Hospital, the Confinement is a Medicare approved Confinement;
c) We have verified that the Covered Person's coverage is in force on the date the expense is Incurred;
d) the Covered Person has satisfied any deductible that applies; and
e) the Covered Person has not exhausted the Calendar Year or Lifetime Maximum Benefits.

The Schedule of Benefits and Amounts shows the applicable deductibles and Maximum Benefit Amounts.

EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled on the date his or her coverage terminates, We will extend the Policy Benefit Period for expenses Incurred as the result of that disability, subject to all Policy benefit provisions, exclusions, and limitations.

For Medicare Part A Eligible Expenses: A Policy Benefit Period for Medicare Part A Eligible Expenses which is established prior to termination extends until the first to occur of:

a) the date the Covered Person has not been Confined in a Hospital or Skilled Nursing Facility for a period of 60 consecutive days; or
b) the 365th day after termination.

If a Covered Person's coverage terminates while he or she is receiving approved Hospice Care, the Hospice Care benefits of the Policy will continue until the end of the Hospice Care benefit period, as defined by Medicare.

For Medicare Part B Eligible Expenses: The Policy Benefit Period for Medicare Part B Eligible Expenses extends until the end of the Calendar Year quarter following termination as shown below:

Termination Month	**Extension Date**
January, February, March	June 30 of same year
April, May, June	September 30 of same year
July, August, September	December 31 of same year
October, November, December	March 31 of next year.

GENERAL LIMITATIONS

Limitation: If a Covered Person has not enrolled in both Medicare Part A and Part B, We will pay the benefits under the Policy as if he or she had enrolled in both parts of Medicare.

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition means any Injury or Sickness for which a Covered Person received medical advice or treatment within the 6 month period immediately before:

a) his or her effective date of coverage; or
b) the effective date of an increase in coverage;

whichever is applicable.

Conditions Prior to Effective Date: During the first 6 months from a Covered Person's effective date of insurance, expenses Incurred for Pre-existing Conditions are not covered.

Change from a Related Policy: If a Covered Person's coverage has converted without interruption:

a) from the Related Policy;
b) to this Policy;

We will credit toward satisfaction of the above Pre-existing Condition Limitation the period that he or she was continuously covered by the Related Policy immediately before the conversion. Any expenses Incurred which are payable under an Extension of Benefits provision of the Related Policy will not be payable under this Policy.

Replacement Coverage: If the Covered Person:

a) has purchased coverage under this Policy in order to replace coverage under a prior Retiree group health policy; and
b) he or she provides proof of coverage under such prior policy;

We will credit toward satisfaction of this Policy's Pre-existing Condition Limitation the period that he or she was continuously covered by the prior policy immediately before his or her effective date under this Policy.

However, if benefits under this Policy are greater than those provided by the prior policy, the 6 month Pre-existing Condition Limitation of this Policy will apply only to the increased benefits.

Conditions Prior to Effective Date of Increase in Coverage: During the first 6 months following the date a Covered Person makes a change in coverage that increases benefits, the increased portion of the benefit will not be payable for expenses Incurred due to Pre-existing Conditions.

This Pre-existing Conditions Limitation will not apply to any increase in coverage due to changes in Medicare benefits.

GENERAL EXCLUSIONS
APPLICABLE TO ALL PLANS

The Policy does not cover:

a) any expense that is:
   1. not a Medicare Eligible Expense; or
   2. beyond the limits imposed by Medicare for such expense; or
   3. excluded by name or specific description by Medicare;

   except as specifically provided under the Policy;
b) any portion of a covered expense to the extent paid by Medicare;
c) any benefits payable under one benefit of the Policy to the extent payable under another benefit of the Policy; and
d) covered expenses Incurred after coverage terminates except as stated in the Extension of Benefits provision.

CLAIM PROVISIONS

Notice of Claim: The Covered Person must give Us, or Our representative, written notice of a claim within 20 days after a covered loss begins. If Covered Person cannot give notice within that time, it must be given to Us as soon as reasonably possible. Such notice must include the Covered Person's name, Covered Person's address, Covered Person's ID number and the Policy number.

Claim Forms: Our representative or We will send forms to the Covered Person to provide proof of loss within 15 days after We receive a notice of claim. If We do not send the forms within 15 days, the Covered Person may submit any other written proof that fully describes the nature and extent of a Covered Person's claim.

Sending Proof of Loss: Written proof of loss must be sent to Us within 90 days after:

a) the end of each month of Our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If proof is not given by the time it is due, it will not affect the claim if:

a) it was not possible to give proof within the required time; and
b) proof is given as soon as possible; but
c) not later than 1 year after it is due, unless the Covered Person is not legally competent.

Claim Payment: When we determine that the Covered Person is eligible to receive benefits, We will pay all benefits due:

a) on a monthly basis, after We receive the proof of loss, while the loss and Our liability continue; or
b) immediately after We receive the proof of loss following the end of Our liability.

We will pay any other benefit due immediately after We receive the proof of loss.

Payment of Claim: We will pay any benefits due and not assigned, to the Covered Person, if living. Otherwise, We will pay any benefits due for a loss that occurred prior to the Covered Person's death to his or her estate.

If a benefit due is payable to a minor, it will be paid to his or her guardian. If a benefit due is payable to:

a) the Dependent's estate;
b) a minor; or
c) a person not competent to give valid release for payment;

We may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to the Covered Person by blood or marriage who We believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

If the Covered Person provides Us with a Written Release to do so, We may, at Our option, pay benefits directly to the institution or person rendering:

a) Hospital services; or
b) nursing, medical, or surgical services;

unless the Covered Person or the person to whom the benefit is payable requests otherwise in writing no later than the time the proof of loss is filed with Us.

Written Release means any written direction from the Covered Person to pay benefits to the institution or person rendering the service. We will not require that the services be rendered by a particular institution or person.

CLAIM PROVISIONS (Continued)

Assignment: The Covered Person may assign the benefits of this Policy to the institution, or person rendering service as allowed in the Payment of Claims provision. The Covered Person may not assign the Policy in any other way or to any other person.

Legal Actions: Legal action cannot be taken against Us:

a) sooner than 60 days after the date proof of loss is given; or
b) 3 years after the date written proof of loss is required to be given according to the terms of the Policy.

Changes to Medicare: Benefits are adjusted annually or upon the effective date established by Medicare to reflect changes in the federal government's Medicare program. These changes may cause increases or decreases in benefit amounts payable under the Policy.

Insurance Fraud: Insurance Fraud occurs when a Covered Person and/or Covered Person's Employer provides Us with false, incomplete or misleading information with the intent to injure, defraud, or deceive Us. It is a crime if the Covered Person and/or Covered Person's Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter, and prosecute those who commit Insurance Fraud. We will pursue all available remedies if the Covered Person and/or Covered Person's Employer perpetrate Insurance Fraud.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement (Hartford – Plan Year 2017).

COUNTY OF FRESNO

Chairman, Board of Supervisors

ATTEST:
BERNICE E. SEIDEL, Clerk
Board of Supervisors
By Susan Bishop
Deputy

DATE: 3-22-17

REVIEWED & RECOMMENDED FOR APPROVAL

Paul Nerland, Director of Human Resources

APPROVED AS TO LEGAL FORM

Daniel C. Cederborg, County Counsel

APPROVED AS TO ACCOUNTING FORM

Oscar Garcia,
Auditor-Controller/Treasurer-Tax Collector

FOR ACCOUNTING USE ONLY:

Fund No:	1060
Subclass:	10000
ORG No:	89250200
Account No:	7185