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 1/1/19 – 12/31/19 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.

Table of Contents

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

$242.21

*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
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.

TABLE OF CONTENTS

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 2019).

CONTRACTOR

_____
(Authorized Signature)

_____
Print Name & Title

_____

_____
Mailing Address

COUNTY OF FRESNO

_____
Sal Quintero
Chairperson of the Board of Supervisors
of the County of Fresno

ATTEST:
Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By: _____
Deputy

FOR ACCOUNTING USE ONLY:

Fund No: 1060
Subclass: 10000
ORG No: 89250200
Account No: 7185