CERTIFICATE OF GROUP TRICARE SUPPLEMENT INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

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

Policyholder: American Military Insurance Trust
Policy Number: AGP-5943
Policy Effective Date: January 1, 2019
Policy Anniversary Date: January 1

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

Signed for the Company

Lisa Levin, *Secretary*

Michael Concannon, *President*

READ YOUR CERTIFICATE CAREFULLY: You have a 30 day right to examine Your Certificate. If You are not satisfied, You may return it to Us within 30 days from the date You received it. In that event, We will consider it void from Your Coverage Effective Date and any premiums paid will be refunded. Any claims paid under this Certificate during the initial 30 day period will be deducted from the refund.

Notice to buyer: The Policy may not cover all of the costs associated with medical care received during the period of coverage. Please review carefully all of The Policy's limitations contained in this Certificate.

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

A note on capitalization in this Certificate:

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

TABLE OF CONTENTS

SCHEDULE

Eligible Classes for Coverage:

NOTICE TO BUYER: **You must be enrolled in TRICARE insurance coverage to be eligible for supplement coverage under this Policy.**

Class	Description of Eligible Persons	TRICARE Supplement Plan
1	Covered persons who are covered by TRICARE, and who are a: - Retired Member - Retired Reserve Member - Member's Spouse - Member's Dependent Child(ren) - Member's Dependent Child(ren) enrolled in TRICARE Young Adult	TRICARE Select Supplement TRICARE Prime Supplement TRICARE Retired Reserve Supplement TRICARE Young Adult Select Supplement TRICARE Young Adult Prime Supplement

TRICARE Supplement Benefits, Deductibles, Maximums and Coinsurance:

TRICARE SELECT, TRICARE RETIRED RESERVE & TRICARE YOUNG ADULT SELECT SUPPLEMENT PLANS Formerly covered under prior policy MZ0925783 or coverage effective on or after January 1, 2019	
Benefit	**Benefit Payment**
TRICARE Annual Outpatient Deductible Credit	100% of the amount of Eligible Charges used to satisfy the Covered Person's Outpatient deductible under TRICARE Select.
Plan Deductible	None
Inpatient Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount until the TRICARE Catastrophic Cap is reached.
Outpatient Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount until the TRICARE Catastrophic Cap is reached.
Excess Benefit	100% of all Covered Expenses in excess of the TRICARE allowed amount not to exceed the Legal Limit.
Ambulatory Surgery Services (same day)	100% of the Cost Share not paid by TRICARE until the TRICARE Catastrophic Cap is reached.
Pharmacy Reimbursement Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount until the TRICARE Catastrophic Cap is reached.

TRICARE PRIME & TRICARE YOUNG ADULT PRIME SUPPLEMENT PLANS **With Point of Service Benefits** Formerly covered under prior policy MZ0925783 or coverage effective on or after January 1, 2019	
Benefit	**Benefit Payment**
TRICARE Annual Outpatient Deductible Credit	Not applicable to TRICARE Prime
Plan Deductible	None

TRICARE Point of Service Deductible Credit	50% of the amount of Eligible Charges used to satisfy the Covered Person's annual Point of Service deductible under TRICARE Prime.
Point of Service Policy Maximum	No annual maximum
Inpatient Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount after the TRICARE Point of Service Annual Deductible, if applicable, until the TRICARE Catastrophic Cap is reached.
Outpatient Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount after the TRICARE Point of Service Annual Outpatient Deductible, if applicable, after the TRICARE Annual Outpatient Deductible until the TRICARE Catastrophic Cap is reached.
Excess Benefit	100% of all Covered Expenses in excess of the TRICARE allowed amount not to exceed the Legal Limit.
Ambulatory Surgery Services (same day)	100% of the Cost Share not paid by TRICARE after the TRICARE Annual Outpatient Deductible until the TRICARE Catastrophic Cap is reached**.**
Pharmacy Reimbursement Benefit	100% of the Cost Share remaining after TRICARE pays, not to exceed any TRICARE allowed or negotiated amount after any applicable TRICARE Annual Outpatient Deductible until the TRICARE Catastrophic Cap is reached.

GENERAL DEFINITIONS

Terms used in this Certificate are defined below. Some terms specific to a benefit are defined in the respective benefit provision.

Active Duty means active duty in a Uniformed Service of the United States for more than 30 days.

Age means the age a Covered Person has attained on any Premium Due Date.

Ambulatory Surgery Services means a non-emergency elective surgical procedure which would otherwise be performed on an inpatient basis, but is performed the same day a person enters and leaves a Hospital or ambulatory surgical center. No overnight hospitalization is required and less than a full day's charge is made for room and board services.

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

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

Company means Hartford Life and Accident Insurance Company.

Confined or **Confinement** means being an Inpatient in:

1)a Hospital; or
2)a Skilled Nursing Facility;

due to Injury or Sickness.

Copayment means the amount the Covered Person may be required to pay as his or her share of the cost of medical services, treatments or supplies under insurance coverage. Also see the definition of Policy Copayment.

Cost Share means the amount the Covered Person is required to pay for services received from a TRICARE provider whether expressed as a cost share amount or copayment fee, or as a coinsurance percentage of the contracted fee for the service.

Covered Expense means the reasonable expense incurred by a Covered Person for needed medical or surgical treatment, services or supplies. The expense must be:

1) incurred for the sole purpose of treating the Covered Person's Injury or Sickness;
2) prescribed by the Covered Person's attending Physician, except for routine nursing services; and
3) incurred while the Covered Person is an Inpatient in the Hospital to be covered under an Inpatient Benefit; or
4) incurred while the Covered Person is not confined as an Inpatient in a Hospital to be covered under an Outpatient Benefit.

In addition, the expense must be incurred:

1) by the Covered Person while the Covered Person is covered under such benefit; for
2) a Confinement, service, or
3) supply that is covered under TRICARE.

Covered Person means You and any Dependents insured under this Certificate.

Deductible means the amount the Covered Person must pay for medical services, treatment or supplies before his or her insurance starts to pay under TRICARE or other coverages.

Dependent or **Dependents** means Your:

1)Spouse;
2)Dependent Child(ren)**.**

Dependent Child(ren) means:

1) Your unmarried child, stepchild, legally adopted child;
2) any child for whom You have legal guardianship; or
3) any other child related to You by blood or marriage You provide at least 50% of their financial support;

provided the child is primarily dependent upon You for financial support by reason of age or disability**.**

Dependent Child(ren) age limit is:
1)the date the child attains Age 21; or
2)the date the child attains Age 23 if enrolled as a full time student; or
3)the date the child attains Age 26 if enrolled in the TRICARE Young Adult program.

Divorce or **Divorced** means:
1)legal divorce;
2)annulment;
3)dissolution of marriage; or
4)legal separation**.**

Employer means Your employer.

Employer Health Program means a program issued to or sponsored by a Covered Person's employer which provides coverage for basic hospital, medical or surgical expenses incurred as a result of injury or sickness. Such program may be an insurance policy, a hospital or medical service contract, a Blue Cross or Blue Shield contract, a medical practice or other prepayment plan, or a managed care plan.

Family means the Member's family consisting only of his or her eligible Dependents.

Family Member means the Covered Person's parent, spouse, children, siblings, grandparent, aunt, uncle, first cousin, nephew or niece. This includes those relations listed acquired through an adoption, in-laws and step-relatives.

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

Hospital means an institution which TRICARE recognizes as a hospital**.**

Incur or **Incurred** means that, with respect to any expense, the Covered Person receives, or has received, the treatment, service or supply that gives rise to the expense. A Covered Person is considered to incur an expense on the date the treatment, service or supply is received.

Inpatient means a patient in:
1)a Hospital; or
2)a Skilled Nursing Facility;

being charged one full day's room and board.

Injury means bodily injury:
1)resulting directly from accident; and
2)resulting independently of disease or bodily infirmity.

Loss resulting from:
1)Sickness or bacterial infections, except a pus-forming infection that occurs through an accidental wound or bacterial infections which result from an accidental injury or accidental, involuntary or unintentional ingestion of a contaminated substance; or
2)medical or surgical treatment of a Sickness;

is not considered as resulting from Injury.

Legal Limit means the highest amount the Covered Person can be charged for a covered service by Physicians and other health care providers who do not accept TRICARE assignment. The limit is 15% over TRICARE Allowed Amount.

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

Member means a member of the Policyholder or Participating Organization.

To be eligible for coverage, the Member must:

1) be under Age 65;
2) not be eligible for Medicare;
3) not be on Active Duty; and
4) be covered under the TRICARE plan that matches Your plan under The Policy**.**

Outpatient means a person who receives medical treatment, services or supplies at a Hospital or licensed ambulatory care facility for which there is no charge for room and board.

Outpatient Deductible means the Outpatient deductible, as defined and determined by TRICARE.

Participating Organization means an organization participating in the trust named on the face page of this Certificate and covered under The Policy.

Period of Confinement means an interval of time during which a Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility.

A Period of Confinement:

1) begins on the date the Covered Person is admitted to a Hospital or Skilled Nursing Facility while he or she is covered by The Policy; and
2) ends on the date the Covered Person is discharged from the Hospital or Skilled Nursing Facility.

Physician means a person who is:

1)a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art that We recognize or are required by law to recognize;
2)licensed to practice in the jurisdiction where care is being given;
3)operating within the scope of his or her license; and
4)not the Covered Person or a Family Member.

Plan Administrator means a third party administrator mutually agreed upon by Us and the Policyholder.

Point-of-Service means TRICARE Prime enrollees have the freedom to receive services without a referral or authorization.

Policyholder means the legal entity in whose name The Policy is issued, as shown on the face page of this Certificate.

Policy Copayment means the amount, shown in the Schedule, the Covered Person may be required to pay under The Policy as his or her share of the cost of medical services, treatments or supplies.

Premium Due Date means 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.

Primary Insured means the person to whom this Certificate is issued. (Also see You, Yours.)

Prior Policy means the **TRICARE** supplement insurance replaced by insurance under The Policy which was carried or sponsored by the Policyholder or by an organization acquired by the Policyholder on the day before the Policy Effective Date or the Participating Organization Effective Date.

Request means a written request by the Covered Person made on the forms We or the Plan Administrator furnish for making the request.

Retiree or Retired Member means a Member of the Organization who is retired from Active Duty and is covered by TRICARE.

Schedule means the schedule of benefits for this Certificate.

Service Disabled Member means a Member of the Policyholder or Participating Organization who has a service related total disability and is at least 80% disabled, as determined by the Veteran's Administration.

Sickness means illness, disease, pregnancy or disorder of the body.

Skilled Nursing Facility means an institution that:

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

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

1)the aged, or for rest, custodial or educational care;
2)alcoholism and drug addiction;
3)the treatment of Mental Illness.

Spouse means any individual who is recognized as Your spouse under applicable state law.

To be eligible for coverage, Your Spouse must:

1) be under Age 65;
2) not be eligible for Medicare;
3) not be on Active Duty; and
4) be covered under the TRICARE plan that matches his or her plan under The Policy**.**

Totally Disabled or Total Disability means disability caused by an Injury or Sickness that continuously confines the Covered Person:

1) in a Hospital;
2) in a Skilled Nursing Facility; or
3) indoors under the regular care and attendance of a Physician.

A period of total disability will not end:

1) by going to and from a doctor's office or Hospital for treatment; or
2) by resting out-of-doors at home;

if advised to do so by a Physician.

TRICARE means the Department of Defense regional managed care program for members of the Uniformed Services and their families, and survivors and retired members and their families. TRICARE provides choices for health care delivery: TRICARE Select, a preferred provider organization (PPO) option which offers Cost Share discounts; and TRICARE Prime, health maintenance organization (HMO) option.

TRICARE Allowed Amount means the amount TRICARE determines is a reasonable charge for a Covered Expense.

TRICARE Catastrophic Cap means the amount TRICARE determines is the limit for eligible expenses applied to the TRICARE Outpatient Deductible and cost-share payments for all members of a Family in a Calendar Year. After a Family has incurred Covered Expenses which meet the TRICARE Catastrophic Cap, TRICARE will increase its rate of payment to 100% of the TRICARE Allowed Amount for all members of such Family.

TRICARE Young Adult Program means the health care option of TRICARE for qualified adult-age Dependent Children.

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

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

Well Baby Care means expenses incurred during the first 6 years after birth for well child care recognized by TRICARE.

Well Baby Care does not include the Hospital's charge for nursery care of a well newborn.

You or Your means a Member who is currently insured under The Policy and this Certificate. (See also Primary Insured.)

ELIGIBILITY AND EFFECTIVE DATES

Your Coverage Effective Date: You will become covered under The Policy on the later of:

1)the Policy Effective Date if You were enrolled under the Prior Policy; or

2)Your coverage effective date under the Policy;

provided the required premium is paid, subject to the Deferred Effective Date.

However, in no event will You become covered under The Policy before the date You become a member of an Eligible Class for Coverage.

Deferred Effective Date: If on the date that You are to become covered under the Policy, You are Confined in a Hospital or Skilled Nursing Facility, Your coverage will start on the day after You are discharged.

Dependents' Coverage Effective Date: An eligible Dependent will become covered under The Policy on the latest of:

1)the Policy Effective Date if Your Dependents were enrolled under the Prior Policy; or

2)Your Dependent's effective date under the policy;

provided the required premium is paid, subject to the Dependents' Deferred Effective Date.

Spouse coverage may be elected independent of the Member's coverage.

However, in no event will a Dependent become covered under The Policy before the date he or she becomes a member of an Eligible Class for Coverage.

Dependents' Deferred Effective Date: If on the date that Your Dependent is to become covered under The Policy, Your Dependent is Confined in a Hospital or Skilled Nursing Facility, Your Dependents' coverage will start on the day after he or she is discharged. This provision does not apply to a newborn child.

Eligibility Restrictions: If both You and Your Spouse are Members and are eligible for coverage, coverage may not be duplicated by applying as Dependents of each other and both cannot enroll Dependents. No Covered Person can be insured as a Dependent of more than one Member under The Policy.

Newborn Child Coverage: If, while covered under the Policy, You or Your covered Spouse have a newborn child, the child will become covered under the Policy for 31 days after the date of birth with You or Your covered Spouse.

The Child will be covered for Injury or Sickness under the same plans and benefits that apply to;

1) Your other Dependent Child(ren), if You have other children covered under The Policy; or
2) Your Spouse, if Your Spouse is covered under The Policy; or if not;
3) You.

The child's coverage will cease on the 31st day following the child's effective date unless We receive notice and required premium to continue the child before that date.

Continuity from a Prior Policy: Coverage under The Policy will begin and will not be deferred if, on the day before the Policy Effective Date, a Covered Person:

1) was insured under a Prior Policy; and
2) is not eligible to receive benefits under the Prior Policy.

Continued coverage will mirror the Covered Person's coverage under the Prior Policy on the date immediately before the Policy Effective Date.

Insurance under this provision is subject to payment of premium to Us when due.

Changes in Coverage: You may change Your coverage and your Dependent's coverage at any time.

Any increase in coverage is subject to the Deferred Effective Date provision.

TERMINATION PROVISIONS

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

1)the date The Policy terminates or the Participating Organization ceases to participate in The Policy;
2)the first of the month following the date You are no longer in a class eligible for coverage;
3)the date The Policy no longer covers Your class;
4)the date the required premium is due but not paid, subject to the Individual Grace Period or Policyholder Grace Period;
5)the first of the month following the date You Request We terminate Your coverage;
6)the date You cease to be covered under TRICARE;
7) the date You cease to be a Member of the Policyholder or a Participating Organization;
8) the date You attain Age 65 unless You are not eligible for Medicare and can provide documentation of such from the Social Security Administration;
9)the date You become eligible for Medicare (unless You reside in an area where Medicare is not available. Coverage will not terminate until You reside in an area where Medicare is available);

unless continued under the Continuation Provisions.

In addition to the events listed, if Your coverage was continued in accordance with the Widow or Widower's Continuation provision, Your coverage will end on the Premium Due Date on or next following the date You remarry or enter or enter into a legal relationship recognized as a spouse.

Termination of coverage will be without prejudice to any claims which originated before the effective date of termination**.**

Termination of Your Dependents' Coverage:

Coverage for Your Dependent(s) will end on the earliest of the following:

1)the date The Policy terminates or the Participating Organization ceases to participate in The Policy;
2)the first of the month following the date Your Dependent is no longer in a class eligible for coverage;
3)the date The Policy no longer covers Your Dependent's class;
4)the date Your Dependent ceases to be covered under TRICARE;
5)the date the required premium is due but not paid, subject to the Individual Grace Period or Policyholder Grace Period;
6)the date You cease to be a Member of the Policyholder or a Participating Organization**;**
7)the date We or the Policyholder terminate Dependent coverage;
8)the first of the month following the date You Request We terminate Dependent coverage;
9)the date Your Dependent's coverage ends in accordance with the Newborn or Newly Adopted Child Coverage provision;
10) the date Your Spouse attains Age 65 unless he or she is not eligible for Medicare and can provide documentation of such from the Social Security Administration;
11) the date Your Dependent becomes eligible for Medicare unless he or she resides in an area where Medicare is not available. Coverage will not terminate until Your Dependent resides in an area where Medicare is available**;**
12) the date Your Spouse no longer satisfies the definition of Spouse; or
13) the date Your child no longer satisfies the definition Dependent Child(ren);

unless coverage is continued under the Continuation Provisions.

Termination of coverage will be without prejudice to any claims which originated before the effective date of Termination**.**

Individual Grace Period: We will allow an Individual Grace Period of 31 days from the Premium Due Date for payment of each premium due after the initial premium. Insurance will be continued during the Individual Grace Period. If the Covered Person has a covered loss during the Individual Grace Period, You will be liable for payment of any premium accruing during the period We continued coverage.

The Individual Grace Period will not continue coverage after any date on which coverage would end, as stated in Termination Provisions.

Reinstatement of Coverage: If Coverage terminates because premiums have not been paid, it may be reinstated under The Policy if:

1) We receive a Request for reinstatement within 3 months of when the premium was due;
2) the Covered Person was previously covered under The Policy; and
3) the Covered Person is eligible for coverage under The Policy;

except for voluntary termination of coverage.

Reinstated coverage is subject to all other terms and provisions of The Policy.

CONTINUATION PROVISIONS

Coverage may not be continued under more than one of the following Continuation Provisions.

In no event will the amount of coverage increase while coverage is continued in accordance with one of the following Continuation Provisions.

Coverage will not continue after:

1)a date the coverage would normally end under the Termination Provisions; or
2)the Premium Due Date that premium is due and not paid, subject to the Individual Grace Period or Policyholder Grace Period.

In all other respects, the terms of coverage for Your Dependents remain unchanged.

Incapacitated Child Continuation: If on the date a Dependent Child reaches the limiting age for a Dependent Child and is:

1) covered under The Policy;
2) mentally or physically disabled and incapable of earning his or her own living; and
3) unmarried and primarily dependent upon You for support and maintenance;

his or her coverage will not terminate solely due to age. However, You must give Us notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:

1) the child qualifies as an incapacitated child; and
2) the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, We will not require proof more than once each year**.**

Dependent Continuation: If Your Dependent coverage under The Policy will terminate because Your coverage ends due to:

1) Medicare eligibility;
2) attainment of Age 65: or
3) Your death;

then Your Spouse may continue the coverage for any of Your Dependents who are covered under The Policy on the date Your coverage terminates. We must receive Your Spouse's Request and the required premium to continue the coverage within 90 days of the date Your coverage terminates.

Solely for the purpose of continuing the coverage under The Policy, the Spouse will then be considered the Primary Insured. However, this will not continue the Dependent's coverage beyond a date the coverage would normally terminate under the Dependent Termination provision of this Policy.

Widow or Widower's Continuation: If You die while Your Spouse is covered under The Policy, Your Spouse may continue:

1) his or her coverage; and
2) coverage for any of Your Dependents who are covered under The Policy on the date of Your death.

We must receive Your Spouse's Request and the required premium to continue the coverage within 90 days of the premium due next following Your date of death.

Solely for the purpose of continuing the coverage under The Policy, the Spouse will then be considered the Primary Insured. However, this will not continue the Dependent's coverage beyond a date the coverage would normally terminate under the Dependent Termination provision of this Policy.

Any coverage continued under this provision will terminate on the Premium Due Date on or next following the date the Spouse remarries.

Extension of Benefits for Total Disability: If a Covered Person is Totally Disabled on the date his or her coverage under The Policy terminates, We will extend Inpatient benefits for expenses Incurred as the result of that disability until the first to occur of:

1) the date the Covered Person is no longer Totally Disabled; or
2) the 90th day from the date the Covered Person's Inpatient benefit ended.

If a Covered Person is Totally Disabled on the date his or her Outpatient benefit ends, then his or her benefits under The Policy will continue up to 90 days from the date of termination. The continuation will only apply to expenses incurred for the Injury or Sickness that caused the Total Disability.

If a Covered Person is not Totally Disabled on the date his or her Outpatient Benefit terminates, no benefits will be provided for Outpatient expenses he or she incurs after the date of termination.

TRICARE SUPPLEMENT BENEFITS

The Schedule shows the benefits available for each plan. Please check the Schedule to determine if benefits are available under Your or Your Dependent's plan.

Inpatient Benefit: We will pay the amount shown in the Schedule for benefits for a Covered Person's Period of Confinement in a Hospital or Skilled Nursing Facility. The Period of Confinement must:

1) be due to Sickness or Injury;
2) begin while the Covered Person is covered under this benefit;
3) be approved by TRICARE**.**

Outpatient Benefit: When a Covered Person incurs Covered Expenses while the Covered Person is not confined in a Hospital or Skilled Nursing Facility, We will pay the amount shown in the Schedule, provided that the expenses are:

1) due to Sickness or Injury;
2) Incurred while the Covered Person is covered under this benefit;
3) approved by TRICARE;
4) Incurred after the Covered Person has satisfied the Annual Outpatient Deductible charged by TRICARE, if applicable**.**

Excess Benefit: We will pay the amount shown in the Schedule of the difference between the actual TRICARE charge as billed and the TRICARE Allowed Amount, after any applicable deductible is met. However, Our payment will not exceed any charge over the Legal Limit. The expenses must be Incurred by a Covered Person while covered under this benefit.

However, We will not pay this benefit if:

1) the provider of the medical care accepts TRICARE assignment; or
2) the service or supply is not covered by TRICARE.

TRICARE Annual Outpatient Deductible Credit: We will pay amount shown in the Schedule of the Covered Person's expenses which are used to satisfy the Annual Outpatient Deductible charged by TRICARE, provided that the Annual Outpatient Deductible is satisfied after the Effective Date of coverage. Reimbursement for the Annual Outpatient Deductible will be prorated for a Covered Person who is covered less than a full year.

Ambulatory Surgery Services: We will pay the amount shown in the Schedule for Covered Expenses Incurred in connection with Ambulatory Surgery Services performed:

1) in a facility licensed as an ambulatory surgical center approved by TRICARE; or
2) in a Hospital, provided the Hospital charges less than full day's room and board;

provided the surgery is performed on the same day as the ambulatory service is provided.

Pharmacy Reimbursement Benefit: When a Covered Person Incurs Covered Expenses for prescriptions filled at a pharmacy or through home delivery, We will pay the amount shown in the Schedule, provided that the expenses are:

1) due to Sickness or Injury;
2) Incurred while the Covered Person is covered under this benefit; and
3) approved by TRICARE.

Point of Service Policy Maximum:
If the Covered Person exercises the Point of Service option of TRICARE Prime, we will reimburse the Cost Share amount shown in the Schedule:

1) for Inpatient services; and
2) for Outpatient services, after the Point of Service Outpatient Deductible for such expenses has been satisfied**.**

TRICARE Point of Service Annual Outpatient Deductible Credit: We will pay the amount shown in the Schedule of the Covered Person's expenses which are used to satisfy the Point of Service Annual Outpatient Deductible charged by TRICARE, provided that the Point of Service Annual Outpatient Deductible is satisfied after the Effective Date of

coverage. Reimbursement for the Point of Service Annual Outpatient Deductible will be prorated for a Covered Person who is covered less than a full year.

PLAN CONVERSIONS

The following Plan Conversions are provided under The Policy. All premiums due will be adjusted according to the conversion made. The conversion will not become effective if any additional premium required is not paid.

In no event will a Plan Conversion continue coverage beyond the date that it would have otherwise terminated in accordance with the Termination Provisions of The Policy.

The new coverage will become effective on the first day of the month on or after the date Your TRICARE status or coverage changed. If You do not report the change in eligibility within 60 days, the change will be effective the first day of the month on or after receipt of the Request.

TRICARE Comprehensive Retiree Supplement to TRICARE Prime Supplement Conversion: If, while covered by a TRICARE Comprehensive Retiree Supplement, You enroll in TRICARE Prime, the TRICARE Comprehensive Retiree Supplement will terminate and coverage will be transferred to a TRICARE Prime Supplement plan of Your choice. Covered Expenses incurred under TRICARE Prime will only be payable under the terms of the TRICARE Prime Supplement. You must give Us/the Plan Administrator written notice of Your TRICARE Prime enrollment as soon as possible, but at least within 60 days.

TRICARE Prime Supplement to TRICARE Comprehensive Retiree Supplement Conversion: If, while covered by a TRICARE Prime Supplement, You enroll in TRICARE Select, the TRICARE Prime Supplement will terminate and coverage will be transferred to a TRICARE Comprehensive Retiree Supplement plan of Your choice. Covered Expenses incurred under TRICARE Select will only be payable under the terms of the TRICARE Comprehensive Retiree Supplement. You must give Us/the Plan Administrator written notice of Your TRICARE Prime enrollment as soon as possible, but at least within 60 days.

EXCLUSIONS AND LIMITATIONS

Exclusions: The Policy does not cover:

1) injury or sickness resulting from war or act of war, whether war is declared or undeclared;
2) intentionally self-inflicted injury;
3) suicide or attempted suicide, whether sane or insane.

Limitations: The Policy limits coverage for:

1) routine physical exams and immunizations, except when:
    a. rendered to a child up to 6 years from the child's birth; or
    b required for school enrollment (but not sports physicals) by a Covered Child aged 5 through 11**;**
2) domiciliary or custodial care;
3) eye refractions and routine eye exams except when rendered to a child up to 6 years from the child's birth;
4) eyeglasses and contact lenses;
5) prosthetic devices, except those covered by TRICARE;
6) cosmetic procedures, except those resulting from Sickness or Injury, while a Covered Person;
7) hearing aids;
8) orthopedic footwear;
9) care for the mentally or physically incapacitated if the care is required because of the mental or physical incapacitation;
10) drugs which do not require a prescription, except insulin;
11) dental care unless such care is covered by TRICARE, and then only to the extent that TRICARE covers such care;
12) any confinement, service, or supply that is not covered under TRICARE;
13) Hospital nursery charges for a well newborn, except as specifically provided under TRICARE;
14) any routine newborn care except Well Baby Care;
15) expenses in excess of the TRICARE Catastrophic Cap;
16) that part of any Covered Expense which is in excess of the TRICARE Allowed Amount, except as otherwise stated in the plan benefits;
17) expenses which are paid in full by TRICARE;
18) any part of a Covered Expense which the Covered Person is not legally obligated to pay because of payment by a TRICARE alternative program;
19) any claim under more than one of the TRICARE Supplement Plans. If a claim is payable under more than one plan or benefit, payment will only be made under the provision that provides the highest coverage.

TRICARE Catastrophic Cap: TRICARE will increase its rate of payment to 100% of the TRICARE Allowed Amount when a Covered Person has met the TRICARE Catastrophic Cap. After the TRICARE Catastrophic Cap has been met, we will not duplicate benefits by paying any part of the Cost Share which is payable under TRICARE.

Non-Duplication of Coverage under Employer Health Program: If a claim payable under The Policy is also payable under an Employer Health Program with TRICARE as the secondary payor, we will limit our payment to an amount which, when added to the amounts paid by the Employer Health Program and TRICARE, will not exceed 100% of TRICARE Covered Expenses.

Other TRICARE or CHAMPVA Supplement Policy Limitation (Over-insurance Limitation)

If a Covered Person is insured under any other TRICARE Supplement policy underwritten by Us, any claim for benefits is only payable under one policy. The Covered Person (or their Spouse or estate, in the event of death) may elect under which policy benefits are payable.

We will return the amount of premium paid for any other TRICARE Supplement policy that is declined by the Covered Person retroactive to the later of:

1) the last date any benefit was paid for any Covered Person under the other TRICARE Supplement policy; or
2) the effective date of insurance for the Covered Person under the other TRICARE Supplement policy.

GENERAL PROVISIONS

Statements: In the absence of fraud, all statements made by a Covered Person will be considered representations and not warranties.

Time Limit on Certain Defenses: After a Covered Person has been insured under The Policy for 2 years during his or her lifetime, no statement made by him or her, except an intentionally fraudulent misstatement, will be used to reduce or deny a claim beginning after the 2 year period. To be used, the statement must:

1)be in writing;
2)be signed by the Covered Person who made it; and
3)a copy must be given to him or her.

If the Covered Person is not of the age of majority, then the statement must be signed by the Primary Insured.

Legal Actions: No legal action may start:

1)until 60 days after proof of loss has been given; or
2)more than 3 years after the time proof of loss is required to be given.

Misstatement of Age: If the age of any Covered Person has been misstated:

1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

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

Conformity with State and Federal Laws: Any provision of The Policy or Certificate that is contrary to any applicable law shall be amended to meet the minimum requirements of the law.

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

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

CLAIM PROVISIONS

Notice of Claim: Notice of claim may be given to Us or Our representative within 20 days after the start of any loss covered by The Policy, or as soon as reasonably possible. Notice of claim may be submitted as instructed on the applicable form or mailed to Our Home Office in Hartford, CT. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

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

Claim Forms: When We receive written Notice of Claim, We will send claim forms. If the claimant does not receive the forms within 15 days after written notice of claim is sent, proof of loss may be sent to Us without waiting to receive the claim forms.

Proof of Loss: The claimant must send written proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of Loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Physical Examinations and Autopsy: We, at our own expense, shall have the right and opportunity to have:

1) a Covered Person for whom a claim is made examined by a Physician of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims: Benefits payable under this Certificate will be paid within 30 days after Our receipt of due written proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Payment of Claims: Unless benefit payments are assigned as stated below, all benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:

1) Your surviving Spouse, if the Spouse is a Covered Person; or if none, then to
2) Your estate.

If, at the time of Your death, any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then We may pay up to $1,000 to a person who is related to You by blood or marriage and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Assignment of Benefit Payments: You may assign the Covered Person's benefit payments to the institution or person rendering service by giving Us a written release. You may not assign any coverage or rights and duties under this Certificate in any other way or to any other person.

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

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

Claim Appeal: On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so he or she must submit a Request within 180 days of receipt of the claim denial. The claimant may:

1) Request copies of all documents, records, and other information relevant to the claim; and
2) submit written comments, documents, records and other information relating to the claim.

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

Overpayment Recovery: We have the right to recover any amount that is an overpayment. In the absence of an assignment, as described in Assignment of Benefit Payments above, You have the obligation to reimburse Us any such amount within 90 days after the date of the overpayment.

If You do not reimburse Us in a timely manner, We have the right to:

1)recover such overpayments from:
   a) You;
   b) any other person to, or for whom payment, was made; and
   c) Your estate;

2)reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made;

3)refer the unpaid balance to a collection agency; and

4)pursue and enforce all legal and equitable rights in court.