GROUP BENEFIT PLAN

MICRON TECHNOLOGY, INC.

Life, Supplemental Life, Accidental Death and Dismemberment, Supplemental Accidental Death and Dismemberment and Supplemental Dependent Life

The following provisions are applicable to residents of Florida and Maryland.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL OF THE BENEFITS REQUIRED BY MARYLAND.

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Group Life Insurance Benefits

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
As of the
Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that We have issued and delivered the Group Insurance Policy (Policy) to the Policyholder. The Policy insures the Policyholder's employees who:

- are eligible for the insurance;
- become insured; and
- continue to be insured,

according to the terms of the Policy.

The terms of the Policy which affect an employee's insurance are summarized in the following pages.

This Certificate of Insurance, and the following pages, will become Your Booklet-certificate. The Booklet-certificate is a part of the Policy. This Booklet-certificate replaces any other which We may have issued to the Policyholder to give to You under the Policy specified herein.

Terence Shields, ***Secretary***

Michael Concannon, ***Executive Vice President***

Some of the terms used within this Booklet-certificate are capitalized and have special meanings. Please refer to the definitions at the end of this Booklet-certificate when reading about Your benefits.

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

The Policyholder:	MICRON TECHNOLOGY, INC.
The Policy Number:	GL-674815
Policy Effective Date:	January 1, 2004

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF JANUARY 1, 2022.

Anniversary Date:	January 1 of each year, beginning in 2023.

Who is eligible for coverage?

Eligible Class(es):	All Active Full-time Employees scheduled to work an average of 38 hours per week, 48 weeks per year, or Part-time employees scheduled to work an average 20 hours per week who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees

All persons who are insured for employee coverage will be eligible for coverage for Dependents.

When will You become eligible? (Eligibility Waiting Period)
You will be eligible for coverage on the first day of the month following Your date of hire.

The waiting period will be reduced by the period of time You were an Active Full-time or Part-time Employee with the Employer under the Prior Plan.

When will You become eligible for Dependent Coverage?
You will become eligible for Dependent coverage on the later of:
1. the date You become eligible for employee coverage; or
2. the date You acquire Your first Dependent.

What is the Guaranteed Issue Amount?
This is the Amount of Insurance for which We do not require Evidence of Good Health. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

What is Evidence of Good Health?
Evidence of Good Health is information about a person's health from which We can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by Us.

Inquiries as to the status of Your submission of Evidence of Good Health should be addressed to Your Employer and/or Benefit Administrator. We, Your Employer and/or Benefit Administrator will notify You of approvals. We will notify You, in writing, of any disapprovals.

When will Evidence of Good Health be required?
Evidence of Good Health is required if:
1. You enroll for coverage more than 60 days after the date You are first eligible to do so for an amount of Life Insurance for Yourself or Your Spouse greater than two options or increments; or for an Amount of Life Insurance in excess of $15,000 for a Dependent child; or
2. You elect no coverage when eligible to do so and later opt for coverage for any Amount of Life Insurance for Yourself or Your Spouse greater than two options or increments; or for an Amount of Life Insurance in excess of $15,000 for a Dependent child.

Evidence of Good Health must be provided at Your own expense.

If Evidence of Good Health is not approved in the situation(s) described above, no coverage, including the Guaranteed Issue Amount, will become effective.

Evidence of Good Health is also required if You elect to increase coverage for Yourself by more than two options or increments, provided You do not exceed the Guarantee Issue Amount. Evidence of Good Health is also required if You elect to increase coverage for Your Dependents by more than two options or increment levels, provided You do not exceed the Guarantee Issue Amount.

Evidence of Good Health is also required the first time Your or Your Dependents Amount of Life Insurance would exceed the Guaranteed Issue Amount for any coverage.

If Evidence of Good Health is not approved in this situation, You and Your Dependents are eligible for the amount You requested for which Evidence of Good Health was not required.

Additionally, once approved, Evidence of Good Health will be required again only if Your or Your Dependents Amount of Life Insurance is greater than the Guarantee Issue Amount and You increase Your or Your Dependents coverage election.

However, if:
1. You do not submit Evidence of Good Health; or
2. Your Evidence of Good Health is not approved,

Your Amount of Life Insurance:
1. will increase, but only up to the amount for which You were eligible without having to provide Evidence of Good Health; and
2. will not increase again, or beyond that amount, until Your Evidence of Good Health is approved.

Are there exceptions to the Evidence of Good Health requirement for late enrolling Dependents?
This Evidence of Good Health requirement will be waived for Your Dependent spouse and/or Dependent children, if:
1. You do not elect coverage for Your spouse when first eligible to do so, but, within 60 days following the date You acquire Your first child, You elect spouse coverage; or
2. Your spouse and children were previously covered for life benefits provided by Your spouse's employer group plan; and
    a) Your spouse and children have ceased to be covered under the employer's group plan due to Your spouse's loss of employment or cancellation of that group plan;
    b) Your spouse and children provide Us with proof of prior coverage, including the date of termination, when applying for Dependent Coverage; and
    c) coverage with Us is requested within 60 days of Your spouse's loss of coverage.

Dependents who qualify for this waiver will be subject to all other conditions, restrictions and limitations of the Policy.

AMOUNT OF LIFE INSURANCE
Employee Only

What Life benefits are available to You?

With respect to Full-time Employees:
Basic Amount of Life Insurance:
An amount equal to 1.5 times Your annual rate of basic Earnings, rounded to the next higher multiple of $1,000, if not already such a multiple, subject to a maximum of $2,000,000.

In no event however will Your Basic Amount of Life Insurance be less than $10,000.

With respect to Part-time Employees:
Basic Amount of Life Insurance:
An amount equal to $20,000.

Supplemental Amount of Life Insurance:
a) a Guaranteed Issue Amount equal to an amount You elect in increments of $10,000, subject to a maximum of $300,000 without Evidence of Good Health; or
b) a maximum amount equal to an amount You elect in increments of $10,000, subject to the greater of 5 times Your annual rate of basic Earnings or $300,000 not to exceed $1,000,000 with Evidence of Good Health for all amounts over the Guaranteed Issue Amount of $300,000.

In no event however will Your Supplemental Amount of Life Insurance be less than $10,000.

The Amount You elect is indicated on Your group enrollment form.

Your Amount of Life Insurance will be reduced by any life benefit:
1. paid to You under an accelerated death benefit in the Prior Plan; and
2. in force for You under any disability extension provision of the Prior Plan.

In no event shall the combined amount of:
- Basic Life Insurance
- Supplemental Life Insurance

exceed $2,500,000. In the event the combined amount of such coverages would exceed $2,500,000, any necessary reductions shall come first from the Supplemental Life Insurance and then, if necessary, from the Basic Life Insurance.

In no event shall the combined amount of:
- Basic Principal Sum
- Supplemental Principal Sum

exceed $2,500,000. In the event the combined amount of such coverages would exceed $2,500,000, any necessary reductions shall come first from the Supplemental Principal Sum and then the Basic Principal Sum.

If You convert, does it affect the Amount of Life Insurance benefit payable?
The Amount of Life Insurance under the Policy will be reduced by the amount of the individual life insurance issued in accordance with the Conversion Privilege for reasons other than reductions in coverage.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT (AD&D)

What AD&D Benefits are available to You?

With respect to Full-time Employees:
Basic Principal Sum:
An amount equal to 1.5 times Your annual rate of basic Earnings, rounded to the next higher multiple of $1,000, if not already such a multiple, subject to a maximum of $2,000,000.

With respect to Part-time Employees:
Basic Principal Sum:
An amount equal to $20,000.

Supplemental Principal Sum:
An amount which equals the Supplemental Amount of Life Insurance in force for You.

What AD&D Benefits are available to Your Spouse?

Supplemental Principal Sum:
An amount equal to the Amount of Supplemental Dependent Life Insurance in force for Spouse.

Although Evidence of Good Health is not required for AD&D benefits, the Principal Sum will not exceed the Amount of Life Insurance for which You are insured.

The Amount You elect is indicated on Your group enrollment form.

REDUCED AMOUNTS OF INSURANCE

What reductions in Your coverage will occur due to Your age?
Your Amount of Life Insurance and Principal Sum will decrease by 50% on the Anniversary Date which occurs on or next follows the date You attain age 70.

Additionally, if:
1. You become insured under the Policy; or
2. Your coverage increases,

on or after the date You attain age 70, We reduce the amount of coverage for which You would otherwise be eligible in the same manner.

AMOUNT OF LIFE INSURANCE
Dependent Only

What Life benefits are available to Your Dependents?
NOTE: The amount of spouse coverage may never exceed 100% of the Amount of Life Insurance in force for the employee.

Supplemental Dependent Spouse:
a) a Guaranteed Issue amount You elect in increments of $10,000, subject to a minimum of $10,000 and a maximum of $50,000 without Evidence of Good Health, not to exceed 100% of the Combined Basic and Supplemental Amount of Life Insurance in force for the employee; or
b) a maximum amount You elect in increments of $10,000, subject to a maximum of $500,000 with Evidence of Good Health.

Supplemental Dependent Children:

Option 1:	
less than 6 month(s) of age:	$1,000
6 month(s) of age or older:	$5,000
Option 2:	
less than 6 month(s) of age:	$1,000
6 month(s) of age or older:	$10,000

The Amount You elect is indicated on Your group enrollment form.

What reductions in Your Dependent spouse's coverage will occur due to Your age?
Your Spouse's Amount of Life Insurance and Principal Sum will decrease by 50% on the January 1st Your Spouse attains age 70. The reduction will apply to the Amount of Life Insurance and Principal Sum in force immediately prior to January 1st .

ELIGIBILITY AND ENROLLMENT

Must You contribute toward the cost of coverage?
With respect to Basic Life Insurance and Basic AD&D coverage, You do not contribute toward the cost.

With respect to Supplemental Life Insurance, Supplemental Dependent Life Insurance, Supplemental AD&D and Supplemental Spouse AD&D coverage, You must contribute toward the cost.

How do You enroll?
To enroll You must:
1. complete and sign a group insurance enrollment form which is satisfactory to Us; and
2. deliver it to the Employer.

If You do not enroll within 60 days after becoming eligible, the following limitations will apply to a later enrollment:
1. You must submit Evidence of Good Health; and
2. You may not enroll until an Annual Enrollment Period.

Any such enrollment must be made during the Annual Enrollment Period.

The Annual Enrollment Period is determined by Your Employer on a yearly basis.

When does coverage start?
Your coverage will start on the latest of the dates determined below:
1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 60 days after the date You are eligible;
3. the date We approve Evidence of Good Health which We may have required; or
4. the first day of the calendar year following the Annual Enrollment Period if You enroll during an Annual Enrollment Period.

All of the above effective dates are subject to the Deferred Effective Date provision.

What is the Deferred Effective Date provision for employees?
If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time or Part-time Employee.

Are there exceptions to the Deferred Effective Date provision?
If You were actively at work or on an approved leave of absence in conformity with the Family and Medical Leave Act of 1993, and insured under the Prior Plan on the day before the Policy Effective Date and You would be eligible for coverage on the Policy Effective Date except that You are not able to meet the requirements of the Deferred Effective Date provision, then:
1. the Deferred Effective Date provision will not apply to the original effective date of coverage; and
2. the coverage amount shown in the Schedule of Insurance will not apply to You.

Instead, You will be considered to be insured and your coverage amount will be the lesser of:
1. the Amount of Life Insurance and Principal Sum under the Prior Plan; or
2. the Amount of Life Insurance and Principal Sum shown in the Schedule of Insurance,

reduced by:
1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

You will remain insured under this provision until the first to occur of:
1. the date You return to work as an Active Full-time or Part-time Employee;
2. the date Your insurance terminates for a reason stated under the Termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day You would have been covered under the Prior Plan, had the Prior Plan not terminated.

When does coverage for Your Dependent(s) start?
You are required to enroll for contributory Dependent coverage. To do so You have to complete and sign a group insurance enrollment form acceptable to Us and deliver it to the Employer.

Your spouse will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:
1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for spouse coverage by then; or
2. the date You enroll for Dependent Coverage, if You do so within 60 days after the date You are eligible.

If You enroll for Dependent Coverage more than 31 days after You are first eligible to do so, no coverage will be available without Evidence of Good Health.

Coverage for which We require Evidence of Good Health will be effective on the later of:
1. the date You become eligible; or
2. the date approved by Us.

Each child will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:
1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for child coverage by then; or
2. the date You enroll for coverage for Your child, if You do so within 60 days after the date You acquire the child.

If You enroll for Dependent Coverage more than 60 days after You are first eligible to do so, no coverage will be available without Evidence of Good Health.

Coverage for which We require Evidence of Good Health will be effective once approved by Us.

In no event will Dependent Coverage become effective before the date You become insured.

All effective dates of coverage are subject to the Deferred Effective Date provision for Dependents.

What is the Deferred Effective Date provision for Dependents?
If a Dependent, other than a newborn, is confined at home, in a hospital or elsewhere because of a physical or mental condition on the date insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of insurance, any increase or additional benefit will be deferred until the Dependent is discharged from the hospital or no longer confined and has engaged in substantially all the normal activities of a healthy person of the same age for a period of at least 15 days in a row.

"Confined elsewhere" means the individual is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

When are changes effective?
The provisions, terms and conditions of the Schedule of Insurance or this Booklet-certificate may be modified, amended or changed at any time; consent from any covered individual is not required.

If there is any type of change in Your class, Earnings, the Schedule of Insurance or the Booklet-certificate which:
1. decreases an amount of coverage or deletes, limits or restricts the availability of a benefit or provision, then that decrease, deletion, limitation or restriction will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective;
2. increases an amount of coverage or adds, improves or increases availability of a benefit or provision, then that increase, addition or improvement will be effective on the date the change in class, Earnings, the Schedule of Insurance or the Booklet-certificate is effective, subject to application of the Deferred Effective Date provision and Our approval where Evidence of Good Health is required.

BENEFITS

Life Insurance Benefit

To whom and how are benefits paid?
A completed claim form, a certified copy of the death certificate and Your enrollment form must be sent to the Employer or Us. When the required claim papers are received and approved by Us, the Amount of Life Insurance will be paid.

Benefits payable for a Dependent's death are payable to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by You in writing and on file with the Employer.

Unless You have requested something different, payment will be made as follows:
1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1. up to $500 of Your life insurance to any party that We deem is entitled because of their payment of burial expenses. We will be released from further liability for any amount so paid; and/or
2. the executors or administrators of Your estate; or
3. Your surviving relatives in the following order:
   a) all to Your surviving spouse; or
   b) if Your spouse does not survive You, in equal shares to Your surviving children; or
   c) if no child survives You, in equal shares to Your surviving parents.

If a minor does not have a legal guardian, We may, until such a guardian is appointed, pay the person We deem to be caring for and supporting him. Such payment will be in monthly installments of not more than $200.

What benefit is payable if Your death results from suicide?
No Supplemental Life or Supplemental Dependent Life benefit will be payable if death results from suicide, whether sane or insane, within 2 years of the effective date of Your coverage. Additionally, if death resulting from suicide, whether sane or insane, occurs within 2 years of the effective date of an increase in Your coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 2 year period includes the time coverage was in force under a Prior Plan.

Accelerated Death Benefit

What is the benefit?
If You are or Your Dependent is diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and that person is:
1. less than age 70; and
2. insured for at least $10,000,

then You may request that a portion of that person's Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of $3,000 and a maximum of $500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to $20,000 and You are Terminally Ill, You can request any portion of the life insurance between $3,000 to $16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only $3,000 now, You cannot request the additional $13,000 in the future.

What does Terminal Illness/Terminally Ill mean?
Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.

What if an individual is no longer Terminally Ill?
If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

What limitations apply to this benefit?
The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

What if You made an assignment under this plan?
If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

Accidental Death and Dismemberment (AD&D) Benefit

What conditions are necessary for benefits to become payable?
We will pay a benefit if You or Your Spouse suffer an accidental injury while that individual is insured and:
1. a Loss results directly from such injury, independent of all other causes; and
2. such Loss occurs within 365 days after the date of the accident causing the injury.

When should We be notified of a claim?
A claimant must give Us, or Our appropriate representative, written notice of a claim within 20 days after the Loss happens or starts. If notice cannot be given within that time, it must be given as soon as possible after that.

Such notice must include:
1. the claimant's name and address; and
2. the Policy or account number.

Are special forms required to file a claim?
Within 15 days of receiving a notice of claim, We or Our appropriate representative will send forms to the claimant for providing proof of Loss. If the forms are not provided within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of claim.

When must proof of Loss be given?
Satisfactory written proof of Loss must be sent to Us or Our appropriate representative, within 90 days after the date of such Loss. However, all claims must be submitted to Us within 90 days of the date any individual's insurance terminates.

If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible, but no later than a year after it is due unless the claimant is not legally competent.

When and to whom will Your claim be paid?
Benefits for Loss of life will be paid in accordance with Your life insurance beneficiary designation. Unless otherwise specified, benefits for all other Losses are payable to You.

Benefits for all other Losses will be paid as soon as due written proof is received. Benefits for all other Losses will be paid not more than 60 days after written proof is received.

Any payments other than for Loss of life which are owing at Your death may be paid to Your estate. If 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 Your relative who is entitled to it in Our opinion. Any such payment shall fulfill Our responsibility for the amount paid.

What types of injuries are excluded from coverage?
No benefit will be paid for a Loss caused or contributed to by:
1. sickness;
2. disease;
3. any medical treatment for items (1) or (2);
4. any infection, except a pus-forming infection of an accidental cut or wound;
5. war or any act of war, whether war is declared or not;
6. any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7. any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;
8. taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered by a licensed physician; or
9. the injured person's intoxication.

Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level, meet or exceed the legal presumption of intoxication under the law of the state where the accident took place.

What is the benefit payable?
The benefit payable for any Loss is that which is shown opposite the Loss in the following schedule. The Principal Sum is shown in the Schedule of Insurance. No benefit is payable for any Loss which is not shown in the schedule below.

DESCRIPTION OF LOSS	BENEFIT
Loss of life	Principal Sum
Loss of a hand	One-half the Principal Sum
Loss of a foot	One-half the Principal Sum
Loss of an eye	One-half the Principal Sum
Loss of speech or hearing	One-half the Principal Sum
Loss of thumb and index finger on either hand	One-quarter the Principal Sum
Loss of movement of both upper and lower limbs (Quadriplegia)	Principal Sum
Loss of movement of three limbs (Triplegia)	Three-quarters the Principal Sum
Loss of movement of both lower limbs (Paraplegia)	Three-quarters the Principal Sum
Loss of movement of both upper and lower limbs on one side of the body (Hemiplegia)	One-half the Principal Sum
Loss of movement of one limb (Uniplegia)	One-quarter the Principal Sum
More than one of the above resulting from one accident	Principal Sum or the sum of the Benefits payable for each Loss, whichever is lesser.

Loss means the following:
1. Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint.
2. Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.
3. Loss of speech or hearing means that speech or hearing is lost entirely and the Loss cannot be recovered or restored. Hearing must be lost in both ears.
4. Loss of movement of limbs means that the movement is completely lost and is irreversible.
5. Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

Seat Belt/Air Bag Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You suffer a Loss under the AD&D Benefit, while:
1. a passenger riding in; or
2. the licensed operator of,

an Automobile and, at the time of the accident, You were properly wearing a Seat Belt as verified on the police report, then a Seat Belt Benefit will be payable in addition to the Principal Sum.

What is the Seat Belt Benefit payable?
The Seat Belt Benefit payable is the lesser of:
1. 10% of the Principal Sum; or
2. $10,000.

What conditions are necessary for an Air Bag Benefit to become payable?
If a Seat Belt Benefit is payable, We will pay an additional 5% of the Principal Sum, subject to a maximum of $5,000, as an Air Bag Benefit, provided that:
1. You were positioned in a seat that was equipped with a factory installed Air Bag;
2. You were properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from injury and death. An Air Bag is not considered a Seat Belt.

Automobile means a duly registered, four wheeled, private passenger car, pick-up truck, van, self-propelled motor home or sport utility vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Employer, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications.

Repatriation Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Repatriation Benefit will be paid in addition to the Principal Sum. For a Repatriation Benefit to be payable, the death must occur outside the territorial limits of the state or country of Your place of permanent residence.

What is the Repatriation Benefit payable?
The Repatriation Benefit payable is the lesser of:
1. the expense incurred for:
   a) preparation of Your body for burial or cremation; and
   b) transportation of Your body to the place of burial or cremation; or
2. 5% of the Principal Sum; or
3. $5,000.

Education Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then an Education Benefit will be paid in addition to the Principal Sum. This benefit is payable to each of Your dependents who qualifies as a Student.

Who may qualify as a Student?
A Student, for the purpose of this Education Benefit, means a person who is Your dependent on the date of Your death, and who:
1. is a post-high school student who attends a school for higher learning on a Full-time basis on the date of Your death; or
2. became a Full-time post-high school student in a school for higher learning within 365 days after Your death and was a student in the 12^{th} grade on the date of Your death.

The term "Full-time" student shall mean registered for not less than 12 course credit hours per semester. If the institution establishes full-time student status by a method other than semester credit hours, We reserve the right to determine whether the student qualifies as Full-time.

No benefit is payable to any dependent who has not furnished proof to Us of his Student status.

What is the Education Benefit payable?

The Education Benefit payable is the lesser of:
1. the actual tuition expense for any one school year; or
2. 5% of the Principal Sum; or
3. $5,000.

We will not pay more than one Education Benefit per Student during any one school year.

If the Student is a minor, We will pay benefits to the Student's legal representative.

When will payments terminate?
The Education Benefit will no longer be payable on the first to occur of:
1. the date on which the 4th Education Benefit for a Student is paid; or
2. the end of the 12th consecutive month during which the dependent has not furnished satisfactory proof to Us that he is a Student.

What benefits are payable if no dependent qualifies as a Student?
If no dependent qualifies as a Student, then We will pay $2,500 in accordance with Your beneficiary designation.

Day Care Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Day Care Benefit is payable in addition to the Principal Sum. The Day Care Benefit is payable for each dependent if:
1. such dependent is less than age 7 at the time of death; and
2. proof of such dependent's enrollment in a Day Care Program is provided as described below.

What is the Day Care Benefit payable?
The Day Care Benefit payable is the lesser of:
1. $5,000; or
2. 5% of Your Principal Sum.

One Day Care Benefit is payable each year for each dependent who qualifies for Day Care Benefits. No more than four Day Care Benefits will be payable for each dependent. Payment will be made to the person who has primary responsibility for such dependent's expenses.

What proof must be given?
Proof of a dependent's enrollment in a Day Care Program may be in the form of, but will not be limited to, the following:
1. a copy of the dependent's approved enrollment application in a Day Care Program;
2. canceled check(s) which prove payment for a Day Care Program; or
3. a letter from the Day Care Program stating that the dependent:
   a) is attending a Day Care Program; or
   b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of Your death.

Proof of enrollment must be sent to Us prior to the last day of the 12th month on or next following the date of Your death.

Day Care Program means a program of child care which:
1. is operated in a private home, school or other facility;
2. provides and charges a fee for the care of children; and
3. is licensed as a Day Care Center or is operated by a licensed Day Care Provider, if such licensing is required by the state or jurisdiction in which it is located; or
4. if licensing is not required, provides child care on a daily basis for 12 months a year.

A Day Care Program will not mean a program of child care which is provided by an immediate relative of the child receiving the care. An immediate relative is a sibling, parent, step-parent, grandparent, aunt, or uncle.

What benefits are payable if no person is eligible for Day Care Benefits?
If no dependent qualifies for Day Care Benefits, then We will pay $2,500 in accordance with Your beneficiary designation.

Rehabilitation Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You suffer a Loss other than loss of life, then a Rehabilitation Benefit will be paid in addition to the Principal Sum.

What is the Rehabilitation Benefit payable?
The Rehabilitation Benefit payable is the lesser of:
1. the Expense Incurred for Rehabilitative Training; or
2. 5% of the Principal Sum; or
3. $5,000.

Rehabilitative Training means any training which:
1. is required due to Your injury; and
2. prepares You for an occupation in which You would not have engaged except for the injury.

Expense Incurred means the actual cost of the:
1. training; and
2. materials needed for the training.

The expense must be incurred during the two-year period that begins on the date of Your accident.

Spouse Education Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Spouse Education Benefit will be paid in addition to the Principal Sum. This benefit is payable to Your spouse.

What conditions are necessary for Spouse Education Benefits to become payable?
To qualify for this Benefit, Your spouse must enroll in an Occupational Training program:
1. for the purpose of obtaining an independent source of income; and
2. within one year of the date of Your death.

What is the Spouse Education Benefit payable?
The Spouse Education Benefit payable is the lesser of:
1. the Expense Incurred for Occupational Training; or
2. 5% of the Principal Sum; or
3. $5,000.

We will pay the Spouse Education Benefit immediately after We receive proof that Your spouse has enrolled in an Occupational Training program.

What benefits are payable if there is no surviving spouse?
If there is no surviving spouse, We will pay $2,500 in accordance with Your beneficiary designation.

Occupational Training means any:
1. education;
2. professional; or
3. trade training

program which prepares the spouse for an occupation for which he otherwise would not have been qualified.

Expense Incurred means:
1. the actual tuition charged, exclusive of room and board; and
2. the actual cost of the materials needed

for the Occupational Training program. The expense must be incurred during the two year period that begins on the date of Your death.

Adaptive Home and Vehicle Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You are injured, then an Adaptive Home and Vehicle Benefit will be payable in addition to the Principal Sum. For this Benefit to be payable:
1. such home alterations must be:
   a) made by a person or persons with experience in such alterations; and
   b) recommended by a recognized organization associated with the injury;
2. such vehicle modifications must be:
   a) carried out by a person or persons with experience in such matters; and
   b) approved by the Motor Vehicle Department.

What is the Adaptive Home and Vehicle Benefit payable?
The Adaptive Home and Vehicle Benefit payable is the lesser of:
1. 5% of the Principal Sum; or
2. $5,000; or
3. the actual one-time cost,

for such alterations and/or modifications, incurred within two years from the date of the accident, to Your:
1. principal residence; and/or
2. Private Automobile,

to make the residence accessible to You, or the Private Automobile driveable or rideable for You.

Private Automobile means a four wheeled, private passenger car, station wagon, pick-up truck, van or jeep-type automobile which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Employer, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Coma Benefit
Subject to all conditions and limitations of this AD&D Benefit, if as a result of an injury You:
1. become Comatose, within 31 days from the date of the accident; and
2. remain continuously Comatose for at least 30 days,

then We will pay a Coma Benefit.

What is the Coma Benefit payable?
The Coma Benefit payable is a monthly amount equal to 1% of the Coma Maximum Benefit Amount, for each month after the Waiting Period in which You remain in a Coma.

The Coma Maximum Benefit Amount equals the Principal Sum under the AD&D Benefit, less all other payments under the AD&D Benefit for all losses which are due to the same accident.

When will payments terminate?
The Coma Benefit will no longer be payable on the first to occur of the:
1. end of the month in which You die;
2. end of the month in which You recover from the Coma;
3. date on which the total of Coma Benefit payments equals the Coma Maximum Benefit Amount; or
4. date on which 100 Coma Benefit payments have been made.

Coma means complete and continuous:
1. unconsciousness; and

2. inability to respond to external or internal stimuli.

Critical Burn Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You are Critically Burned as a result of an injury, then a Critical Burn Benefit is payable.

What conditions are necessary for a Critical Burn Benefit to become payable?
You must be Critically Burned as the result of an injury which:
1. occurred while You are covered under the AD&D Benefit; and
2. requires that You undergo reconstructive surgery, as determined by a Physician.

What is the Critical Burn Benefit payable?
The Critical Burn Benefit payable is the lesser of:
1. 5% of the Principal Sum; or
2. the actual cost of the reconstructive surgery; or
3. $5,000.

No benefit is payable under this Benefit for any Loss described in the AD&D Benefit.

Critically Burned means You suffer burns which are certified by a Physician as more severe than second degree burns and which result in Permanent Disfigurement.

Permanent Disfigurement means scarring over at least 25% of the body which will last indefinitely and can only be corrected through reconstructive surgery.

Physician means a legally qualified physician or surgeon other than a physician or surgeon who is related to You by blood or marriage.

Therapeutic Counseling Benefit
Subject to all conditions and limitations of this AD&D Benefit, if You are injured, then a Therapeutic Counseling Benefit will be payable in addition to the Principal Sum. For this Benefit to be payable, the Therapeutic Counseling services must:
1. begin within 90 days after the date of the Loss; and
2. be incurred no later than one year after the date of the Loss.

What is the Therapeutic Counseling Benefit payable?
The Therapeutic Counseling Benefit payable is the lesser of:
1. the Reasonable Expenses incurred for Therapeutic Counseling which exceed benefits provided by any other Plan; or
2. 5% of the Principal Sum; or
3. $5,000.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment or counseling.

Reasonable Expenses means fees and prices which do not exceed those generally charged for similar Therapeutic Counseling in the local area where received by You. For purposes of this Benefit, We reserve the right to determine Reasonable Expenses. An expense is considered to be incurred on the date it is rendered.

Plan means any:
1. group, blanket or franchise health insurance;
2. group hospital, medical service or pre-payment plan;
3. labor-management trustee, union welfare, employer organization or employee benefit organization plan;
4. automobile insurance medical payments benefit or automobile reparations insurance (no fault);
5. governmental program or coverage required or provided by any statute except Medicare; or
6. Workers' Compensation or similar law.

Felonious Assault
Subject to all conditions and limitations of this AD&D Benefit, if:
1. You are injured as the result of a Felonious Assault; and
2. the injury results in a Loss within 90 days after the date of the injury,

then a Felonious Assault benefit is payable in addition to the Principal Sum.

What is the Felonious Assault Benefit payable?
The Felonious Assault Benefit payable is an amount equal to 10% of the Principal Sum.

Felonious Assault means a violent or criminal act directed at You during the course of:
1. a robbery, hold-up, kidnapping or criminal assault; or
2. an attempt at any of the above,

which constitutes a felony under the law.

Such Felonious Assault must not be committed by an employee of the Employer, or by Your family member, or by a member of the household in which You live.

TERMINATION
Employee Coverage

When does Your coverage terminate?
Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:
1. the date the Policy terminates;
2. the last day of the month of the last month for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the last day of the month immediately following the date Your Employer terminates Your employment; or
5. the last day of the month following the date You are absent from work as an Active Full-time or Part-time Employee.

EXCEPTIONS TO TERMINATION

Under what conditions can Your insurance be continued under the continuation provisions?
If You are absent from work as an Active Full-time or Part-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:
1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are on a documented leave of absence, other than Family or Medical Leave, all of Your coverages (including Dependent Life coverage) may be continued until the last day of the month following 12 month(s) in which the leave of absence commenced.

If You are laid off due to lack of work, all of Your coverages (including Dependent Life coverage) may be continued until the last day of the month following 60 days from the date the layoff commenced.

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, all of Your coverages (including Dependent Life coverage) may be continued until the last day of the month following 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your insurance would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level will be that which was in effect on the day before said leave started, subject to any reductions included in the Policy;
4. the amount of Earnings upon which Your benefit may be based, will be that which was in effect on the day before said leave started; and
5. continued coverage will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the Policy terminates;
   c) You or the Policyholder fail to pay premium when due; or
   d) the Policy no longer insures Your class.

In all other respects, the terms of Your insurance remain unchanged.

If You are absent from work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time Employee.

When does Dependent Coverage terminate?

Unless continued in accordance with the Exception to Termination section, a covered Dependent's insurance will terminate on the earliest of:

1. the date Your coverage terminates;
2. the last day of the period for which any required premium contribution is made, if You fail to make any further required contribution;
3. the last day of the month that the Dependent is no longer eligible for Dependent Coverage;
4. the date the Dependent no longer meets the definition of Dependent; or
5. the date We or the Employer terminate Dependent Coverage.

EXCEPTIONS TO TERMINATION

Under what conditions can Dependent child insurance be continued?

If a covered Dependent child reaches the age at which He would otherwise cease to be a Dependent as defined, and the Dependent child is:

1. disabled and incapable of earning His own living ; and
2. unmarried and primarily dependent on You for support and maintenance,

then Dependent coverage will not terminate solely due to age if You submit satisfactory proof of the Dependent child's disability to Us within 31 days of the date the Dependent child reaches such age.

Coverage will continue while the Policy remains in force as long as:

1. the child continues to meet the required conditions; and
2. any required premium is paid.

We will have the right to require satisfactory proof that the child continues to meet the required conditions as often as necessary during the first two years of continuation, but not more than once a year after that.

PORTABILITY

When can a person elect Portability?
You may elect portability if:
1. the Policy is still in force;
2. Your supplemental life insurance terminates because:
   a. Your employment terminates for any reason prior to Retirement; or
   b. You are no longer in an Eligible Class; and
3. You do not currently have coverage for the amount of life insurance You intend to continue under a certificate of insurance issued in accordance with a conversion, portability or other similar provision under this Policy.

A Dependent may elect portability if:
1. the Policy is still in force;
2. He has not reached Retirement status; and
3. His supplemental life insurance terminates because:
   a. Your employment terminates for any reason prior to Retirement;
   b. Your membership in a class eligible for Dependent's coverage ceases;
   c. You die; or
   d. He ceases to be an eligible Dependent as defined, except a child who reaches the limiting age under the Policy.

In order for a Dependent child to continue coverage, You and/or Your spouse must elect continuation.

What does Retirement mean?
Retirement means the date You or Your Dependent attain normal retirement age under the 1983 United States Social Security Act, and any amendments thereto.

Will Conversion be available if a person elects to continue coverage under this Portability provision?
If a person elects to continue all terminated coverage under this portability provision, then the Conversion provision is not available. If a person elects to continue only a portion of terminated coverage under this portability provision, then the Conversion privilege will be available for the remaining amount.

How is Portability elected?
A person must, within 31 days of the date group coverage terminates:
1. make written application to Us; and
2. pay the required premium.

If this is done, We will issue a certificate of insurance under a group portability policy. Such coverage will be:
1. issued without evidence of good health;
2. on one of the forms then being issued by Us for portability purposes; and
3. effective on the day following the date insurance terminates.

The terms and conditions of coverage under the group portability policy will be similar, but may not be identical, to coverage under this plan.

What limitations apply to this benefit?
A person may elect to continue 50%, 75% or 100% of his supplemental amount of life insurance being terminated. Such amount will be rounded to the next higher $1,000, if not already an even multiple thereof. No employees amount of life insurance continued may exceed $500,000. No spouse's amount of life insurance continued may exceed $500,000. No child's amount of life insurance continued may exceed $10,000.

If an election is made to continue 50% or 75% now, a person may not continue any portion of the remaining amount. In no event will a person be able to continue a supplemental amount of life insurance which is less than $5,000 unless he is a Dependent child.

How much does Portability cost?
See Your Employer for the cost.

CONVERSION PRIVILEGE

The following does not apply to any AD&D Benefits.

When can an individual convert?
If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

If the qualifying event is policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy in order to be eligible for this conversion privilege.

What is the conversion policy?
The conversion policy will:
1. be on one of the life insurance policy forms, except term insurance, then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

How much can be converted?
If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:
1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage; or
2. $2,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

How does an individual convert coverage?
To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to Us and pay the premium required for his age and class of risk.

What if death occurs during the conversion election period?
If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

GENERAL PROVISIONS

When can this plan be contested?
Except for non-payment of premium, the Policy cannot be contested after two years from the Policy Effective Date.

No statement relating to insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the individual's lifetime. In order to be used, the statement must be in writing and signed by the affected individual.

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Are there any rights of assignment?
Except for the dismemberment benefits under the AD&D Benefit, You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:
1. the right to make any contributions required to keep the insurance in force;
2. the privilege of converting; and
3. the right to name and change a beneficiary.

No absolute assignment of rights and interest shall be binding on Us until and unless:
1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:
1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

How do You designate or change Your beneficiary?
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

What recourse do You have if Your claim is denied?
On any claim, the claimant or His representative must appeal to Us for a full and fair review.
1. You must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
   b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

Can We have a claimant examined or request an autopsy?
We reserve the right to have a claimant examined and to have an autopsy performed, if not forbidden by law. Any such examinations will be as reasonably required by Us and at Our expense.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written decision will:
1. give the specific reason(s) for the denial;
2. make specific reference to the provisions upon which the denial is based; and
3. provide an explanation of the review procedure.

When can legal action be taken?
Legal action cannot be taken against Us:
1. sooner than 60 days after proof of loss has been furnished; or
2. 3 or more years after the time proof of loss is required to be furnished according to the terms of the Policy.

How does this plan affect Workers' Compensation coverage?
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Physician-patient Relationship
You may choose any licensed physician. We shall not in any way disturb the physician-patient relationship.

DEFINITIONS

Active Full-time or Part-time Employee – An employee who works for the Employer on a regular basis in the usual course of the Employer's business. An employee must work at least the number of hours in the Employer's normal work week. This must be at least an average of 38 hours per week, 48 weeks per year for full-time employees and at least 20 hours for part-time employees. You will be considered actively at work with Your Employer on a day which is one of Your Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a Full-time basis with respect to Full-time employees, or on a Part-time basis with respect to Part-time employees, on that day. You will also be considered actively at work on a paid vacation day or a day which is not one of Your Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

Amount of Life Insurance – This term means both the Basic and Supplemental Life Amounts unless otherwise stated in specific provisions and benefits.

Anniversary Date – The date occurring in each calendar year which is an anniversary of the Policy Effective Date.

Dependent

1. Your spouse; and
2. Your child:
   a) from live birth to age 26 years; or
   b) who is 26 years old or older and is disabled and primarily dependent upon You for financial support. Such child must have become disabled before attaining age 26.

The term "spouse" means an individual who is either:

(1) in a marriage with the employee which is recognized by the law in the state of residence; or
(2) the employee's domestic partner.

The term "domestic partner" means any individual with whom the employee executes a Domestic Partner Affidavit acceptable to Us, to establish that they are domestic partners for purposes of this Policy. Such person will remain a domestic partner as long as he continues to meet the requirements described in the Domestic Partner Affidavit.

The term "child", shall also include Your:

1. stepchild;
2. legally adopted child; and
3. any other child related to You by blood or marriage or domestic partnership and who lives with You in a regular parent-child relationship, provided that You claim such child as a dependent on Your most current federal income tax return Form 1040.

You may not elect coverage for Your Dependent if Your Dependent is covered as an employee under the Policy. Any person who is in full-time military, naval or air force service cannot be a Dependent. A person can be insured as a Dependent of more than one employee under the Policy.

Earnings means base salary or hourly wage from the Employer. Earnings will include mandatory overtime for employees working shifts A, B, C, D, E or F, up to a maximum amount of overtime equal to 6.4 hours in any two week calendar period. Earnings will not include any overtime not specifically referenced above, bonuses, incentive pay plan, shift differential or other fringe benefits or extraordinary compensation.

Employer – The Policyholder named in the Schedule of Insurance.

He/His – He or she. His or her.

Prior Plan – A plan of group term life insurance sponsored by the Employer which was in force on the day before the Policy Effective Date.

We/Us/Our – The Hartford Life and Accident Insurance Company.

You/Your – The employee to whom this Booklet-certificate is issued.

STATUTORY PROVISIONS

CALIFORNIA

LIFE

The definition of Dependent is amended as follows

The term "spouse" means an individual who is either:
a) in a marriage with the employee which is recognized by the law in the state of residence; or
b) in a registered domestic partnership with the employee in accordance with California law.

Reference in this form to an employee's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

DELAWARE

LIFE

The following provision is applicable to residents of Delaware and is included to bring Your Booklet-certificate into conformity with Delaware state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

FLORIDA

LIFE

The following provision is applicable to residents of Florida and is included to bring Your Booklet-certificate into conformity with Florida state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

GEORGIA

LIFE

The following provision is applicable to residents of Georgia and is included to bring Your Booklet-certificate into conformity with Georgia state law.

Replacement of Prior Group Life Insurance

Under "Are there exceptions to the Deferred Effective Date provision?" the paragraph regarding the amount of Your coverage in this replacement situation is replaced with the following:

Instead, You will be considered to be insured and Your coverage amount will be the Amount of Life Insurance and Principal Sum under the Prior Plan, reduced by:
1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

ILLINOIS

LIFE

The following provision is applicable to residents of Illinois and is included to bring Your Booklet-certificate into conformity with Illinois state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

MARYLAND

LIFE

The following provisions are applicable to residents of Maryland and are included to bring Your Booklet-certificate into conformity with Maryland state law.

1. Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

2. Interest on Claims

Is interest payable on death claims?
The following provision shall apply to any Life Insurance or Accidental Death, Dismemberment and Loss of Sight Insurance or Dependent Life Insurance included in this Policy.

Interest will be paid on claims payable for loss of life as follows:
1. If the death benefit is paid within 30 days of the date of death of the insured, no interest is payable.
2. If due proof of death is submitted to Us more than 180 days following the date of death of an insured, interest will accumulate and be payable from the date on which due proof of death is submitted to Us until the date on which the proceeds of the Policy are paid.

The rate of interest per year will be at least 2 ½ % and any amount over 2 ½% which We declare for that year on funds remaining with Us.

MINNESOTA

LIFE

The following provisions are applicable to residents of Minnesota and are included to bring your Booklet-certificate into conformity with Minnesota state law.

1. Continuation of Life Coverage

For Employees Who Have Been Terminated or Laid Off From Employment and Their Covered Dependents.

Regardless of any other provision in the Policy to the contrary, if:
1. Your life insurance is terminated because You are voluntarily or involuntarily terminated or Laid Off from employment; and
2. the Policy remains in force for Active Full-time or Part-time Employees,

then You may elect to continue any life insurance which may be in force for You and Your Covered Dependents at the time You are terminated or Laid Off.

As used above,
1. Laid Off means that there is a reduction in the number of hours You work so that You are no longer eligible for coverage under the Policy;
2. Termination does not include discharge for gross misconduct; and
3. Termination includes retirement.

In order to continue insurance for yourself and Your Covered Dependents, You must pay Your former Employer the cost of continued coverage on a monthly basis. The amount of premium charged may not exceed 102% of the premium paid, either by You or the Employer for life insurance coverage for an Active Full-time or Part-time Employee. Upon request, the Employer will provide You Our written verification of the cost of this coverage.

You may continue coverage until the first to occur of:
1. the date You are insured under another group insurance policy; or
2. the last day of a period of 18 consecutive months following the date of termination or lay off from employment.

When You are terminated or Laid Off from employment, the Employer will inform You of:
1. Your right to continue coverage;
2. the amount of monthly premium; and
3. how, where and by when payment must be made.

Minnesota law requires that if the Employer fails:
1. to notify You of Your right to continue coverage; or
2. to pay the premium after timely receipt,

and, as a result, Your coverage is terminated, then the Employer will be liable for Your coverage to the same extent as if You still had coverage.

You have 60 days from the later of the date:
1. Your coverage would otherwise terminate; or
2. You receive a written notice of Your right to continue coverage,

to elect coverage.

At the end of the 18 month continuation period, You and Your Covered Dependents may elect, at Your own expense, to obtain a personal term life insurance policy from Us.

Such policy will be:
1. issued without evidence of insurability;
2. issued without interruption of coverage;
3. on one of the life insurance policy forms then customarily issued by Us.

In lieu of the above coverage You and Your Covered Dependents may accept a policy providing reduced benefits at a reduced premium rate.

2. Accidental Death, Dismemberment and Loss of Sight Benefits

The exclusions are amended to read as follows:

What types of injuries are excluded from coverage?
No benefit will be paid for a loss caused or contributed to by:
1. sickness;
2. disease;
3. any medical treatment for items (1) or (2);
4. any infection, except a pus-forming infection of an accidental cut or wound;
5. war or any act of war, whether war is declared or not;
6. any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7. any intentionally self-inflicted injury, suicide, suicide attempt, whether sane or insane; or
8. taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered to You by a licensed physician.

3. Conversion Privilege

The Conversion Privilege is revised to include the following provision. This provision replaces the provision entitled "How much can be converted?" which appears in the Conversion Privilege section of Your Booklet-certificate:

How much can be converted?
An individual may convert the full amount of group coverage lost as a result of the qualifying event, reduced by the amount of any other group coverage for which He becomes covered within 31 days of termination of group coverage.

4. Optional Methods of Settlement

Any beneficiary who is due life insurance proceeds of $15,000 or more may choose to receive the payment in a method other than a lump sum by writing to Us and requesting payment in one of the following optional methods:
1. a lifetime income option;
2. an income option for fixed amounts;
3. an income option for fixed time periods; or
4. an option to select an interest bearing account with Us with the right to select another option at a later date.

5. Portability

Minnesota employees are eligible for life portability only if they are employed by a Minnesota employer. All other residents of Minnesota are not eligible for portability coverage.

NEW HAMPSHIRE

LIFE

The following provision is applicable to residents of New Hampshire and is included to bring Your Booklet-certificate into conformity with New Hampshire state law.

Where to Call For Information Regarding a Claim

If You have a question regarding a claim, You or the policyholder may call Us at 1-800-526-6905. When calling, please give Us the following information:

1. the policy number; and
2. the name of the policyholder (employer or organization), as shown in this Booklet-certificate's Schedule of Insurance.

This notice is for information only and does not become a condition of this Booklet-certificate.

NEW JERSEY

LIFE

The following provision is applicable to residents of New Jersey and is included to bring Your Booklet-certificate into conformity with New Jersey state law.

Conversion Privilege

The second paragraph under "When can an individual convert?" is replaced with the following:

If the qualifying event is Policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy and Prior Plans in order to be eligible for this conversion privilege.

Additionally, any death benefits incurred during the 31 day conversion period are payable under the Group Insurance Policy, not the personal life policy.

NEW MEXICO

LIFE

The following provision is applicable to residents of New Mexico and is included to bring Your Booklet-certificate into conformity with New Mexico state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

NEW YORK

LIFE

The following provisions are applicable to residents of New York and are included to bring your Booklet-certificate into conformity with New York state law**.**

1. Conversion Privilege

The Conversion Privilege appearing in the Booklet-certificate is replaced with the following.

CONVERSION PRIVILEGE

The following does not apply to any AD&D Benefits.

When can an individual convert?
If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert His life insurance to a conversion policy without providing Evidence of Good Health.

What is the conversion policy?
The conversion policy will:
1. be on one of the life insurance policy forms then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

At the individual's option, the personal life policy may be preceded by a single-premium one year term insurance policy, subject to the same conditions. If Your insurance terminates due to Your total and permanent disability, You may elect any one of the life insurance policy forms then customarily issued by the Insurer, subject to the same conditions, at the end of the one year period.

The term “Insurer” means Us or any other insurance company which has agreed with Us to issue conversion policies according to this conversion privilege.

How much can be converted?
The amount which may be converted is limited to the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which You become covered within 31 days of termination of group coverage. If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

How does an individual convert coverage?
To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to Us and pay the premium required for His age and class of risk.

If an individual is not given notice of the existence of the conversion privilege within 15 days of the terminating event which results in the conversion option, He will have an additional period in which to exercise conversion rights. This additional period will end 45 days following the date He is given notice of the right to convert or 90 days following the date on which the terminating event which results in the conversion option occurs, whichever occurs first. Written notice of conversion rights will be presented to the individual or mailed by the Employer or Us to the last known address.

What if death occurs during the conversion election period?

If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

2. Proof of Loss

The Proof of Loss paragraph is amended to read as follows:

When must Proof of Loss be given?
Satisfactory written proof of loss must be sent to Us or Our appropriate representative, within 90 days after the date of such loss. However, all claims must be submitted to Us within 90 days of the date any individual's insurance terminates.

If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible.

3. Accelerated Death Benefit

What is the benefit?
If You are or Your Dependent is diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and You are/that person is:
1. less than Normal Retirement Age; and
2. insured for at least $10,000;

then You may request that a portion of Your/that person's Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of the lesser of 25% of the in force Amount of Life Insurance or $50,000, and a maximum of $500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to $20,000 and You are Terminally Ill, You can request any portion of the life insurance between $5,000 to $16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only $5,000 now, You cannot request the additional $11,000 in the future.

What does Terminal Illness/Terminally Ill mean?
Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.

What if an individual is no longer Terminally Ill?
If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted. Any amount paid as an Accelerated Death Benefit is not available for conversion. Please see the Conversion Privilege section.

What limitations apply to this benefit?
The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of this Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

What if You made an assignment under this Policy?

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

4. Suicide

The suicide provision is amended to read as follows.

What benefit is payable if death results from suicide?
No Supplemental Life or Supplemental Dependent Life benefit will be payable if death results from suicide within 2 years of the effective date of coverage. Additionally, if death resulting from suicide, occurs within 2 years of the effective date of an increase in coverage, the death benefit payable is limited to the amount of coverage in force prior to the increase. The 2 year period includes the time coverage was in force under a Prior Plan.

NORTH CAROLINA

LIFE

The following provision is applicable to residents of North Carolina and is included to bring Your Booklet-certificate into conformity with North Carolina state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

OKLAHOMA

LIFE

The following provisions are applicable to residents of Oklahoma and are included to bring Your Booklet-certificate into conformity with Oklahoma state law.

1. Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

2. Fraud Warning

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of insurance fraud.

OREGON

LIFE

The following provision is applicable to residents of Oregon and is included to bring Your Booklet-certificate into conformity with Oregon state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

SOUTH CAROLINA

LIFE

The following provision is applicable to residents of South Carolina and is included to bring Your Booklet-certificate into conformity with South Carolina state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

TENNESSEE

LIFE

The following provision is applicable to residents of Tennessee and is included to bring Your Booklet-certificate into conformity with Tennessee state law.

Conversion Privilege

The Conversion Privilege is amended to include the following paragraph.

If an individual is not given notice of the existence of the conversion privilege 15 days prior to the expiration of the 31 day election period, He will have an additional period in which to exercise conversion rights. This additional period will end 15 days following the date He is given notice of the right to convert or 60 days following the required 31 day election period, whichever occurs first. Written notice of conversion rights will be presented to the individual or mailed by the Employer or Us to the last known address.

TEXAS

LIFE

The following provisions are applicable to residents of Texas and are included to bring your Booklet-certificate into conformity with Texas state law**.**

1. Workers' Compensation Notice

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

2. Insurer Information Notice

IMPORTANT NOTICE	**AVISO IMPORTANTE**
To obtain information or make a Complaint:	**Para Obtener Informacion O Para Someter Una Queja:**
You may call Hartford Life's toll-free telephone number for information or to make a complaint at:	Usted puede llamar al numero de telefono gratis de Hartford's para informacion o para de someter una queja al:
1-888-563-1124 if about a claim **1-800-523-2233 if not about a claim**	**1-888-563-1124 ascerca de un reclamo** **1-800-523-2233 para una queja**
You may also write to Hartford Life P.O. Box 2999 Hartford, CT 06104-2999	Usted tambien puede escribir a Hartford P.O. Box 2999 Hartford, CT 06104-2999
You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:	Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias coberturas, derechos o quejas al:
1-800-252-3439	**1-800-252-3439**
You may write the Texas Department of Insurance P.O. Box 149104 Austin, TX 78714-9104 FAX # (512)475-1771	Puede escribir al Departamento de Seguros de Texas P.O. Box 149104 Austin, TX 78714-9104 FAX # (512)475-1771
PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact Hartford Life first. If the dispute is not resolved, you may contact the Texas Department of Insurance.	**DISPUTAS SOBRE PRIMAS O RECLAMOS**: Si tiene una disputa concerniente a su prima o a un reclamo debe comunicarse con el (la compania) Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).
ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.	**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

UTAH

LIFE

The following provisions are applicable to residents of Utah and are included to bring Your Booklet-certificate into conformity with Utah state law.

1. Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

2. Life Insurance Benefits

The amount We may pay to any party We deem entitled because of their payment of burial expenses is increased to $5,000.

3. Interpretation of Policy Terms and Conditions

The following provision is deleted:

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

VIRGINIA

LIFE

The following provision is applicable to residents of Virginia and is included to bring Your Booklet-certificate into conformity with Virginia state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $10,000.

WASHINGTON

LIFE

The following provisions are applicable to residents of Washington and are included to bring Your Booklet-certificate into conformity with Washington state law.

1. Life Insurance Benefits Amended

The amount We may pay to any party We deem is entitled because of their payment of burial expenses is up to the lesser of 15% of the Amount of Life Insurance or $1,000.

2. Suicide Exclusion

The Suicide Exclusion appearing in Your Booklet-certificate does not apply to You or Your Dependent.

3. Accelerated Death Benefit - Employee and Dependent

The following replaces the benefit of the same title appearing in Your booklet-certificate.

ACCELERATED DEATH BENEFIT

What is the benefit?
If You are or Your Dependent is diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and that person is:
1. less than age 70; and
2. insured for at least $10,000,

then You may request that a portion of that person's Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of $3,000 and a maximum of $500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to $20,000 and You are Terminally Ill, You can request any portion of the life insurance between $3,000 to $16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only $3,000 now, You cannot request the additional $13,000 in the future.

What does Terminal Illness/Terminally Ill mean?
Terminally Ill or Terminal Illness means that the individual has a medical condition which a physician has certified is reasonably expected to result in death within 24 months or less after the date of certification.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.

IF YOU RECEIVE PAYMENT OF ACCELERATED BENEFITS UNDER THIS PLAN, YOU MAY LOSE YOUR RIGHT TO RECEIVE CERTAIN PUBLIC FUNDS SUCH AS MEDICARE, MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY, SUPPLEMENTAL SECURITY INCOME AND POSSIBLY OTHERS.

ANY BENEFITS RECEIVED UNDER THIS PROVISION MAY BE TAXABLE. SEE YOUR PERSONAL TAX ADVISOR FOR FURTHER INFORMATION.

ANY BENEFITS RECEIVED UNDER THIS PROVISION ARE INTENDED TO QUALIFY UNDER SECTION 101(g) (26 U.S.C 101(g)) OF THE INTERNAL REVENUE CODE OF 1986 AS AMENDED BY PUBLIC ACT 104-191.

What if an individual is no longer Terminally Ill?
If diagnosed as no longer Terminally Ill, coverage may or may not remain in force.

Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount.

If coverage does not remain in force, then the reduced amount of coverage may be converted.

What limitations apply to this benefit?
The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

The Accelerated Death Benefit provision does not apply to any Accidental Death, Dismemberment and Loss of Sight coverage, and no payment of an Accelerated Death Benefit will reduce or otherwise affect the amount of benefits available to You under any applicable Accidental Death, Dismemberment and Loss of Sight benefit.

What if You made an assignment?
If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

What if a dispute occurs over whether You are Terminally Ill?
If Your attending physician, and a physician appointed by Us, disagree on whether You are Terminally Ill, Our physician's opinion will not be binding on You. The two parties shall attempt to resolve the matter promptly and amicably. In case the disagreement is not so resolved, You have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either party. Any such arbitration shall be conducted in accordance with the laws of the state of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitration to one party or the other, or may divide the costs equally or otherwise.

WEST VIRGINIA

LIFE

The following provision is applicable to residents of West Virginia and is included to bring Your Booklet-certificate into conformity with West Virginia state law.

Conversion Privilege
The following paragraph replaces the same paragraph appearing in the Conversion Privilege section of the Booklet-certificate.

If the qualifying event is Policy termination or termination of coverage for a class, then the individual must have been insured for at least 3 years under the Policy in order to be eligible for this conversion privilege.

WISCONSIN

LIFE

The following provision is applicable to residents of Wisconsin and is included to bring Your Booklet-certificate into conformity with Wisconsin state law.

Conversion Privilege

The amount of $2,000 appearing in the Life Conversion Privilege is amended to read $5,000.

ERISA INFORMATION

THE FOLLOWING NOTICE CONTAINS IMPORTANT INFORMATION

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

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

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

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1. **Plan Name**

   Group Life and Supplemental Life Plan for employees of MICRON TECHNOLOGY, INC..

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2. **Plan Number**

   LIFE - 506

   ADD - 506

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3. **Employer/Plan Sponsor**

   MICRON TECHNOLOGY, INC.
   8000 S Federal Way
   P. O. Box 6, Mail Stop 727
   Boise, ID 83716-9632

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4. **Employer Identification Number**

   75-1618004

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Life and Supplemental Life.

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6. **Plan Administrator**

   MICRON TECHNOLOGY, INC.
   8000 S Federal Way
   P. O. Box 6, Mail Stop 727

Boise, ID 83716-9632

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

For the Plan

MICRON TECHNOLOGY, INC.
8000 S Federal Way
P. O. Box 6, Mail Stop 727
Boise, ID 83716-9632

For the Policy:

Hartford Life And Accident Insurance Company
200 Hopmeadow St.
Simsbury, CT 06089

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

8. **Sources of Contributions** -- The Employer pays the premium for the insurance, but may allocate part of the cost to the employee. The Employer determines the portion of the cost to be paid by the employee.

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

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

11. **Labor Organizations**

None

12. **Names and Addresses of Trustees**

None

13. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

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

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

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal, and 6) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

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

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

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

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

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

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

The Plan Described in this Booklet

is Insured by the

Hartford Life and Accident Insurance Company

Hartford, Connecticut

Member of The Hartford Insurance Group