GROUP BENEFITS

SENIOR MEDICAL INSURANCE PLAN SUMMARY OF COVERAGE

THE HARTFORD

SILVER PLAN FOR RETIREES OF: ORTHODOX HEALTH PLAN AGP-3203 THROUGH HARTFORD EMPLOYER GROUP INSURANCE TRUST (HEGIT)

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
HOSPITALIZATION [2] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but $1,316	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but $329 per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but $658 per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but $164.50 per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

GBD- 1270 (AGP- 3203 3223)

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEUCTIBLE – Hospital Confinement and Out-Patient Medical Expenses When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible First $183 of Medicare-approved amounts	$0	100%	**$0**
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after ![$250 Deductible (to a lifetime maximum of $50,000)	![**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

! The Foreign Travel Emergency deductible is a separate deductible.

[1] Coverage amounts are valid from the policy effective date to December 31, 2017. This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent

home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

SAPHIRE ENRICHED PLAN DESIGN AND BENEFITS

JANUARY 1, 2017– DECEMBER 31, 2017

MEDICARE PART D PRESCRIPTION DRUG BENEFITS PROVIDED BY EXPRESS SCRIPTS

<table>
<tr><td>DEDUCTIBLE STAGE</td><td colspan="2">Deductible: $0.00</td><td>Because this plan does not have a deductible, this stage does not apply to you.</td></tr>
<tr><td>INITIAL COVERAGE STAGE</td><td colspan="3">During this stage the plan pays its share of the cost of your covered drugs and you will pay your share. For 2017 you stay in this stage until the total cost of your drugs reaches $3,700. Once you reach this limit you move on to the Coverage Gap Stage.</td></tr>
<tr><td>MEMBER CO-PAYS</td><td colspan="2">Retail and Maintenance Drug Pharmacy
<table><tr><th></th><th>1 Month Supply</th><th>2 Month Supply</th><th>3 Month Supply</th></tr><tr><td>Preferred Generics</td><td>$5</td><td>$10</td><td>$15</td></tr><tr><td>Generic</td><td>$10</td><td>$20</td><td>$30</td></tr><tr><td>Preferred Brand</td><td>$25</td><td>$50</td><td>$75</td></tr><tr><td>Non-Preferred Brand</td><td>$60</td><td>$120</td><td>$180</td></tr><tr><td>Specialty Drugs</td><td>33%</td><td>33%</td><td>33%</td></tr></table>
If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.
Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. To find out if your pharmacy is a Maintenance Drug Pharmacy (MDP) that has agreed to provide up to 90-day supply (with no co-pay savings) call the Express Scripts number on the back of your ID card.</td><td>Express Scripts Home Delivery
3 Month/90 Day Supply
Preferred Generics $8
Generic $15
Preferred Brand $56
Non-Preferred Brand $165
Specialty 33%
You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long term basis) by mail through Express Scripts Home Delivery. There is no charge for standard shipping.</td></tr>
<tr><td>COVERAGE GAP STAGE</td><td colspan="3">After your total yearly drug costs reach $3,700 you will continue to pay the same cost-sharing amount as in the Initial Coverage stage, until you qualify for the Catastrophic Coverage Stage.
You stay in this stage until your out-of-pocket costs reach $4,950. This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for the Catastrophic Coverage.</td></tr>
<tr><td>CATASTROPHIC COVERAGE STAGE</td><td colspan="3">During the Catastrophic Stage you will pay the greater of 5% coinsurance or:
$3.30 copayment for covered generic drugs (including brand drugs treated as generics).
$8.25 copayment for all other covered drugs.</td></tr>
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