



**GROUP
BENEFIT
PLAN**

University Hospitals Management Services Organization (UHMSO)

The following provisions are applicable to residents of North Carolina.

**PRE-EXISTING LIMITATION
READ CAREFULLY**

NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THIS CERTIFICATE.

**TERMINATION INFORMATION
YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.**

READ YOUR CERTIFICATE CAREFULLY.

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PS-M-90



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 Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

The Group Insurance Policy insures the employees of the Policyholder who:

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

according to the terms of the Policy.

The terms of the Group Insurance Policy which affect an employee's insurance are contained 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 Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.

Richard G. Costello, Secretary

John C. Walters, President

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.

Policyholder: UNIVERSITY HOSPITALS HEALTH SYSTEM

Group Insurance Policy: GLT-044252

Plan Effective Date: January 1, 2006

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF SEPTEMBER 1, 2009.

This plan of Disability Insurance provides you with loss of income protection if you become disabled from a covered accidental bodily injury, sickness or pregnancy.

Must you contribute toward the cost of coverage?

You do not contribute toward the cost of coverage under Option 1.

You must contribute toward the cost of coverage under Option 2.

Who is eligible for coverage?

Eligible Class(es): All Active Full-time Employees of University Hospitals Management Services Organization (UHMSO) who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees

Full-time Employees: regularly scheduled to work at least 35 hours per week

Maximum Monthly Benefit:

- Option 1: \$2,500
- Option 2: \$15,000

The **Minimum Monthly Benefit** will be the greater of:

- \$100; or
- 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

Benefit Percentage:

- Option 1: 60%
- Option 2: 60%

Annual Enrollment Period: Determined by your Employer on a yearly basis

When will You become eligible? (Eligibility Waiting Period)

You will be eligible for coverage on the date on which You complete a waiting period of 90 days of continuous active service.

The waiting period will be reduced by the period of time You were an Active Full-time Employee with the Employer under the Prior Plan or by a period of time, granted as seniority, within the University Hospitals system.

The Elimination Period is the period of time you must be Disabled before benefits become payable. It is

1. the first 180 consecutive day(s) of any one period of Disability; or
2. with the exception of benefits required by state law, the expiration of any Employer sponsored short term disability or salary continuation program.

MAXIMUM DURATION OF BENEFITS TABLE

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

The above table shows the maximum duration for which benefits may be paid. All other limitations of the plan will apply.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

When will You become eligible?

You will become eligible for coverage on either:

1. the Plan Effective Date, if You have completed the Eligibility Waiting Period; or if not
2. the date on which You complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

How do You enroll?

Eligible Persons will be enrolled automatically by the Employer for Option 1.

Eligible Persons have the option to enroll electronically for Option 2. Your Employer will provide instructions.

If You do not enroll within 30 days after becoming eligible, the following limitations will apply to a later enrollment:

You may not enroll until:

- 1) an Annual Enrollment Period; or
- 2) You have a Change in Family Status.

Any such enrollment must be made during the Annual Enrollment Period or within 30 days of the Change in Family Status.

With regard to new hires, You must enroll within 30 days of the date You have completed the Employer's orientation program.

The dates of the Annual Enrollment Period are shown in the Schedule of Insurance.

What constitutes a Change in Family Status?

A Change in Family Status means:

1. Your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child; or
2. the death of or divorce from Your spouse; or
3. the death of or emancipation of a child.

WHEN COVERAGE STARTS

When does Your coverage start?

If you are not required to contribute toward the plan's cost, your coverage will start on the date you become eligible.

If you must contribute towards the plan's cost, your coverage will start on the date 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 30 days after the date you are eligible; or
3. the first day of January following the Annual Enrollment Period if you enroll during an Annual Enrollment Period.

DEFERRED EFFECTIVE DATE

When will coverage become effective if a disabling condition causes You to be absent from work on the date it is to start?

If You are absent from work due to:

1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date Your insurance or increase in coverage would otherwise have become effective, Your effective date will be deferred. Your insurance, or increase in coverage will not become effective until You are Actively at Work for one full day.

CHANGES IN COVERAGE

Can you change benefit options?

You may change to an option providing increased or decreased benefits only:

1. during an Annual Enrollment Period; or
2. within 30 days of a Change in Family Status.

When will a requested change in benefit options take effect?

If you enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the first day of January following the Annual Enrollment Period.

If you enroll for a change in benefit option within 30 days following a Change in Family Status, the change will take effect on the date you enroll for the change.

Any such increase in coverage is subject to the following limitations:

1. the Deferred Effective Date Provision; and
2. Pre-existing Conditions Limitations.

Any such increase in coverage is subject to the following limitations:

1. the Deferred Effective Date Provision; and
2. Pre-existing Conditions Limitations.

Do coverage amounts change if there is a change in Your class or Your rate of pay?

Your coverage may increase or decrease on the date there is a change in Your class or Monthly Rate of Basic Earnings. However, no increase in coverage will be effective unless on that date You:

1. are an Active Full-time Employee; and
2. are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Rate of Basic Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the plan?

Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, subject to the following limitations on an increase:

1. the Deferred Effective Date provision; and
2. Pre-existing Conditions Limitations.

BENEFITS

When do benefits become payable?

You will be paid a monthly benefit if:

1. You become Disabled while insured under this plan;
2. You are Disabled throughout the Elimination Period;
3. You remain Disabled beyond the Elimination Period;
4. You are, and have been during the Elimination Period, under the Regular Care of a Physician; and
5. You submit Proof of Loss satisfactory to us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly.

When will benefit payments terminate?

We will terminate benefit payment on the first to occur of:

1. the date You are no longer Disabled as defined;
2. the date You fail to furnish Proof of Loss, when requested by us;
3. the date You are no longer under the Regular Care of a Physician, or refuse our request that You submit to an examination by a Physician;
4. the date You die;
5. the date Your Current Monthly Earnings exceed:
 - a) 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;
 - b) an amount that is equal to the product of Your Indexed Pre-disability Earnings and the Benefit Percentage for which You enrolled if You are receiving benefits for being Disabled from Any Occupation;
6. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
7. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
8. the date You refuse to participate in a Rehabilitation program or, refuse to cooperate with or try:
 - a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
 - b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
 - c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
 - d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation,

provided a qualified Physician agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation; or
9. the date You refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS**Are benefits limited for Mental Illness or Substance Abuse?**

If You are Disabled because of:

1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable:

1. only for so long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when You are not so confined, a total of 12 months for all such Disabilities during Your lifetime.

RECURRENT DISABILITY**What happens if You Recover during the Elimination Period but become Disabled again?**

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, provided the number of days You return to work as an Active Full-time Employee are no more than 30 days.

Any day of a period of Recovery will not count towards the Elimination Period.

After the Elimination Period, when a return to work as an Active Full-time Employee is followed by a recurrent Disability, and such Disability is:

1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided the Group Insurance Policy remains in force.

If You return to work as an Active Full-time Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. A new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits. The Elimination Period and Maximum Duration of Benefits Table are in the Schedule of Insurance.

The term "Period of Disability" as used in this provision means a continuous length of time during which You are Disabled under this plan.

CALCULATION OF MONTHLY BENEFIT

How are Disability benefits calculated?

Return to Work Incentive

If You remain Disabled after the Elimination Period, but work while You are Disabled, we will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:

1. multiply Your Pre-Disability Earnings by the Benefit Percentage for which You enrolled;
2. compare the result with the Maximum Benefit for which You enrolled; and
3. from the lesser amount, deduct Other Income Benefits.

Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, we will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1. the day You first start such work; or
2. the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, we will calculate Your Monthly Benefit as follows:

1. multiply Your Monthly Income Loss by the Benefit Percentage for which You enrolled;
2. compare the result with the Maximum Benefit for which You enrolled; and
3. from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

What happens if the sum of the Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of Pre-disability Earnings?

We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

If an overpayment occurs, we may recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the Minimum Monthly Benefit.

How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Benefit Percentages and Maximum Benefits are shown in the Schedule of Insurance.

REHABILITATION

What is Rehabilitation?

Rehabilitation is a process of working together to plan, adapt, and put into use options and services to meet Your return to work needs.

A Rehabilitation program may include, when we consider it to be appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
 - a) support groups;
 - b) physical therapy;
 - c) occupational therapy; and
 - d) speech therapy;
4. work-place modification to the extent not otherwise provided;
5. job placement; and
6. transitional work, and
7. similar services.

FAMILY CARE CREDIT BENEFIT

What if You must incur expenses for Family Care Services in order to participate in a Rehabilitative program?

If You are working as part of a program of Rehabilitative Employment, we will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from a Rehabilitative program, subject to the following limitations:

1. Family Care means the care or supervision of:
 - a) Your children under age 13; or
 - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2. the maximum monthly deduction allowed for each qualifying child or family member is:
 - a) \$350 during the first 12 months of Rehabilitative Employment; and
 - b) \$175 thereafter,but in no event may the deduction exceed the amount of Your monthly earnings;
3. Family Care Credits may not exceed a total of \$2,500 during a calendar year;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
 - a) You are no longer in a Rehabilitative program; or
 - b) Family Care Credits for 24 months have been deducted during Your Disability; and
7. no Family Care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under the plan if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

SURVIVOR INCOME BENEFIT

Will Your survivors receive a benefit if You should die while receiving Disability Benefits?

If You die while receiving benefits under this plan, a Survivor Benefit will be payable to:

1. Your surviving Spouse; or
2. Your surviving Child(ren), in equal shares, if there is no surviving Spouse.

If a minor Child is entitled to benefits, we may, at our option, make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The Benefit is one payment of an amount that is 3 times the lesser of:

1. Your Monthly Income Loss multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance for which You enrolled.

If there is no surviving Spouse or Child(ren), payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the Survivor Benefit to any overpayment which may exist on Your claim.

The following terms apply to this Benefit:

“Spouse” means Your wife or husband who:

1. is mentally competent; and
2. was not legally separated from You at the time of Your death.

“Child” means Your son or daughter under age 23 who is dependent on You for financial support.

WORKPLACE MODIFICATION BENEFIT

Will our Rehabilitation program provide for modifications to the workplace to accommodate a Disabled employee's return to work?

We will reimburse Your Employer for the expense of reasonable modifications to Your workplace to accommodate Your Disability and enable You to return to work as an Active Full-time Employee. To qualify for this benefit:

1. Your Disability must be covered by this plan;
2. the Employer must agree to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the essential duties of Your job; and
3. any proposed modifications must be approved in writing by us.

Benefits paid for such workplace modification shall not exceed the amount equal to Your Pre-disability Earnings multiplied by the Benefit Percentage for which You enrolled.

We have the right, at our expense, to have You examined or evaluated by:

1. a physician or other health care professional; or
2. a vocational expert or rehabilitation specialist,

of our choice so that we may evaluate the appropriateness of any proposed modification.

The Employer's costs for approved modifications will be reimbursed after:

1. the proposed modifications made on Your behalf are complete;
2. we have been provided written proof of the expenses incurred to provide such modification; and
3. You have returned to work as an Active Full-time Employee.

This Workplace Modification benefit will not be payable if:

1. the Employer does not incur any cost in making the modification;
2. we have not given written approval of the modification prior to expenses being incurred; or
3. You become self-employed, or return to work for another employer.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this plan.

PRE-EXISTING CONDITIONS LIMITATIONS

Are there any other limitations on coverage?

No benefit will be payable under the plan for any Disability that is due to, contributed to by, or results from a Pre-existing Condition, unless such Disability begins after the last day of 12 consecutive month(s) during which you have been continuously insured under this plan.

The amount of a benefit increase, which results from a change in benefit options, a change of class or a change in the plan, will not be paid for any Disability that is due to, contributed to by, or results from a Pre-existing condition, unless such Disability begins after the last day of 12 consecutive month(s) during which you have been continuously insured for the increased benefit amount.

Pre-existing Condition means:

1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which you received Medical Care during the 3 month period that ends the day before:

1. your effective date of coverage; or
2. the effective date of a Change in Coverage.

Medical Care is received when:

1. a Physician is consulted or medical advice is given; or
2. treatment is recommended, prescribed by, or received from a Physician.

Treatment includes but is not limited to:

1. medical examinations, tests, attendance or observation; and
2. use of drugs, medicines, medical services, supplies or equipment.

CONTINUITY FROM A PRIOR PLAN

Is there continuity of coverage from a Prior Plan?

If you were:

1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

For purposes of this continuity of coverage provision only, you shall be considered actively at work while on any scheduled leave of absence for reasons other than your own Disability or any regularly scheduled vacation day, holiday or weekend day, or any unscheduled absence for reasons other than your own Disability otherwise permitted by Employer normal leave or absence policies.

If you become insured under the Group Insurance Policy on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:

1. the Plan Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

However, the Pre-existing Conditions Limitation will apply after the Plan Effective Date to the amount of a benefit increase which results from a change in benefit options, a change of class or a change in the Plan.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1. the Monthly Benefit which was paid by the Prior Plan; or
2. the Monthly Benefit provided by this plan.

No payment shall be made after the earlier to occur of:

1. the date payments would have ceased under the Prior Plan; or
2. the date payments cease under this plan.

If you received Monthly Benefits for Disability under the Prior Plan, and:

1. you returned to work as an Active Full-time Employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

Prior Plan means the long term disability insurance carried by the Policyholder on the day before the Plan Effective Date.

EXCLUSIONS

What Disabilities are not covered?

The plan does not cover, and no benefit shall be paid for any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war (declared or not);
3. caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation; or
4. caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1. was sponsored by the Employer; and
2. was terminated before the Effective Date of this plan,

no benefits will be payable for the Disability under this plan.

TERMINATION

When does Your coverage terminate?

You will cease to be covered on the earliest to occur of the following dates:

1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures Your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which You make any required premium contribution, if You fail to make any further required contribution;
5. the date You cease to be an Active Full-time Employee in an eligible class including:
 - a) temporary layoff;
 - b) leave of absence; or
 - c) a general work stoppage (including a strike or lockout); or
6. the date Your Employer ceases to be a Participant Employer, if applicable.

Does Your coverage continue if Your employment terminates because You are Disabled?

If You are Disabled and You cease to be an Active Full-time Employee, Your insurance will be continued:

1. during the Elimination Period while You remain Disabled by the same Disability; and
2. after the Elimination Period for as long as You are entitled to benefits under the Policy.

Must premiums be paid during a Disability?

No premium will be due for You:

1. after the Elimination Period; and
2. for as long as benefits are payable.

Do benefits continue if the plan terminates?

If You are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:

1. will continue as long as You remain Disabled by the same Disability; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no effect on our liability under this provision.

May coverage be continued during a family or medical leave?

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, Your Employer may continue Your insurance for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your coverage 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, or the amount of earnings upon which Your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
 - a) the leave terminates prior to the agreed upon date;
 - b) the termination of the Group Insurance Policy;
 - c) non-payment of premium when due by the Policyholder or You;
 - d) the Group Insurance Policy no longer insures Your class; or
 - e) Your Employer ceases to be a Participant Employer, if applicable.

GENERAL PROVISIONS

What happens if facts are misstated?

If material facts about You were not stated accurately:

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

No statement made by You relating to Your 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 Your lifetime. In order to be used, the statement must be in writing and signed by You.

When should we be notified of a claim?

You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include Your name, Your address and the Group Insurance Policy number.

Are special forms required to file a claim?

When we receive a notice of claim, You will be sent forms for providing us with Proof of Loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

What is Proof of Loss?

Proof of Loss may include but is not limited to the following:

1. documentation of:
 - a) the date Your Disability began;
 - b) the cause of Your Disability;
 - c) the prognosis of Your Disability;
 - d) Your Earnings or income, including but not limited to copies of Your filed and signed federal and state tax returns; and
 - e) evidence that You are under the Regular Care of a Physician;
2. any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3. the names and addresses of all:
 - a) Physicians and practitioners of healing arts You have seen or consulted;
 - b) hospitals or other medical facilities in which You have been seen or treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;
4. Your signed authorization for us to obtain and release:
 - a) medical, employment and financial information; and
 - b) any other information we may reasonably require;
5. Your signed statement identifying all Other Income Benefits; and
6. proof that You and Your dependents have applied for all Other Income Benefits which are available. You will not be required to claim any retirement benefits which You may only get on a reduced basis.

All proof submitted must be satisfactory to us.

When must Proof of Loss be given?

Written Proof of Loss must be sent to us within 90 days after the start of the period for which we owe payment. 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
3. not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, we must receive the proof within 30 days of the request.

What additional Proof of Loss is Hartford Life entitled to?

To assist us in determining if You are Disabled, or to determine if You meet any other term or condition of the policy, we have the right to require You to:

1. meet and interview with our representative; and
2. be examined by a doctor, vocational expert, functional expert, or other medical or vocational professional of our choice.

Any such interview, meeting or examination will be:

1. at our expense; and
2. as reasonably required by us.

We reserve the right to determine if Your Proof of Loss is satisfactory. Unless we determine You have a valid reason for refusal, we may deny, suspend or terminate Your benefits if You refuse to be examined, or meet to be interviewed.

When must one apply for Social Security Benefits?

Upon Hartford Life's request, You must apply for Social Security disability benefits. You must apply within 45 days from the date of Hartford Life's request. If the Social Security Administration denies Your claim for benefits, You will be required to follow the process established by the Social Security Administration to:

1. request a reconsideration of the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals on Your claim for Social Security benefits.

How does Hartford Life estimate disability benefits under the United States Social Security Act?

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your Dependent may be eligible to receive.

When we determine that You or Your Dependent may be eligible for benefits, we may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1. You apply for Social Security disability benefits and pursue all required appeals in accordance with the provision entitled "When must one apply for Social Security Benefits?"; and
2. You have signed a form authorizing the Social Security Administration to release information about awards directly to us; and
3. You have signed and returned Hartford Life's reimbursement agreement, which confirms that You agree to repay all overpayments.

If we have reduced Your Monthly Benefit by an estimated amount and:

1. You or Your Dependent are later awarded Social Security disability benefits, we will adjust Your Monthly Benefit when we receive proof of the amount awarded; or
2. Your application for Social Security disability benefits has been denied, we will adjust Your Monthly Benefit when You provide us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If we have not reduced Your Monthly Benefit by an estimated Social Security disability benefit, we will adjust Your Monthly Benefit upon receipt of proof of the amount of Social Security disability benefits awarded.

If we owe You a refund, we will make such refund in a lump sum. If Your Monthly Benefit has been overpaid, You must make a lump sum refund to us equal to all overpayments, in accordance with the provision entitled "How does Hartford Life exercise the right to recover overpayments?"

When does an overpayment occur?

An overpayment occurs:

1. when we determine that the total amount we have paid in benefits is more than the amount that was due to You under the plan; or
2. when payment is made by us that should have been made under another group plan.

This includes, but is not limited to, overpayments resulting from:

1. retroactive awards received from sources listed in the Other Income Benefits definition;
2. failure to report, or late notification to us of any Other Income Benefit(s) or earned income;
3. misstatement;
4. fraud; or
5. any error we may make.

In case of an overpayment, we have the right to recover the payment from one or more of the following:

1. You;
2. any other organization;
3. any other insurance company; and
4. any other person to or for whom payment was made.

How does Hartford Life exercise the right to recover overpayments?

We have the right to recover from You any amount that we determine to be an overpayment. You have the obligation to refund to us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Plan.

If benefits are overpaid on any claim, You must reimburse Hartford Life within 30 days.

If reimbursement is not made in a timely manner, Hartford Life has the right to:

1. recover such overpayments from Your estate;
2. reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3. refer Your unpaid balance to a collection agency; and
4. pursue and enforce all its legal and equitable rights in court.

Who gets the benefit payments?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to Your estate, a person who is a minor or a person who is not legally competent, then we may pay up to \$1,000 to any of Your relatives who is entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid.

When are payment checks issued?

When we determine that You are Disabled and eligible to receive benefits, we will pay accrued benefits at the end of each month that You are Disabled. We may, at our option, make an advance benefit payment based on our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as satisfactory Proof of Loss is received.

What notification will You receive if Your claim is denied?

If a claim for benefits is wholly or partly denied, You 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 Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

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.

When can legal action be started?

Legal action cannot be taken against us:

1. sooner than 60 days after due Proof of Loss has been furnished; or
2. three years after the time written Proof of Loss is required to be furnished according to the terms of the Policy (five years in Kansas; six years in South Carolina).

What are our subrogation rights?

If an Insured Person:

1. suffers a Disability because of the act or omission of a third party;
2. becomes entitled to and is paid benefits under the Group Insurance Policy in compensation for lost wages; and
3. does not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights the Insured Person may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability.

How do we deal with fraud?

Insurance Fraud occurs when You and/or Your Employer, with the intent to injure, defraud or deceive us, provides us with false information or files a claim for benefits that contains any false, incomplete or misleading information. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrates Insurance Fraud.

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 Group Insurance Policy.

DEFINITIONS

The terms listed will have these meanings.

Actively at Work

You will be considered to be 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 on that day. You will be deemed to be actively at work on 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.

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours indicated in the Schedule of Insurance.

Any Occupation means an occupation for which you are qualified by education, training or experience, and that has an earnings potential greater than an amount equal to the lesser of the product of your Indexed Pre-disability Earnings and the Benefit Percentage for which you enrolled and the Maximum Monthly Benefit shown in the Schedule of Insurance.

Current Monthly Earnings means the monthly earnings you receive from:

1. the Employer while Disabled;
2. other employment.

However, if the other employment is a job you held in addition to Active Full-time Employment with the Employer, then:

1. during the Elimination Period, and while eligible to receive benefits for being Disabled from Your Occupation;
2. any earnings from this other employment will be Current Monthly Earnings only to the extent that such earnings exceed the average monthly earnings you were receiving from this other job during the 6 month period immediately prior to becoming Disabled.

Current Monthly Earnings will also include the amount of pay for another or modified job position, which may be offered to you by the Employer or other employer, if you refuse the offer. The requirements of such position must be within your capabilities as described by your Physician, and consistent with your education, training and experience.

Disability or Disabled means:

1. during the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation;
2. for the 12 months following the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation, and as a result your Current Monthly Earnings are less than 80% of your Indexed Pre-disability Earnings;
3. after that, you are prevented from performing one or more of the Essential Duties of Any Occupation.

If at the end of the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation, but your Current Monthly Earnings are greater than 80% of your Pre-disability Earnings, your Elimination Period will be extended for a total period of 12 months from the original Date of Disability, or until such time as your Current Monthly Earnings are less than 80% of your Pre-disability Earnings, whichever occurs first.

Your Disability must be the result of:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that you are Disabled.

Employer means the Policyholder.

Essential Duty means a duty that:

1. is substantial, not incidental;
2. is fundamental or inherent to the occupation; and
3. can not be reasonably omitted or changed.

To be at work for the number of hours in your regularly scheduled workweek is also an Essential Duty.

Indexed Pre-disability Earnings when used in this policy means your Pre-disability Earnings adjusted annually by adding the lesser of:

1. 10%; or
2. the percentage change in the Consumer Price Index (CPI-W).

The adjustment is made January 1st each year after You have been Disabled for 12 consecutive months, and if You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, we may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31st, and the prior year's CPI-W as of July 31st, divided by the prior year's CPI-W.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral or emotional disorders, but excluding demonstrable, structural brain damage.

Monthly Benefit means a monthly sum payable to you while you are Disabled, subject to the terms of the Group Insurance Policy.

Monthly Income Loss is the difference of your Pre-disability Earnings less your Current Monthly Earnings.

Monthly Rate of Basic Earnings means your regular monthly rate of pay from the Employer just prior to the date you become Disabled:

1. including contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and
2. not including bonuses, commissions, overtime pay or expense reimbursements for the same period as above.

Other Income Benefits mean the amount of any benefit for loss of income, provided to you or to your family, as a result of the period of Disability for which you are claiming benefits under this plan. This includes any such benefits for which you or your family are eligible or that are paid to you, to your family or to a third party on your behalf, pursuant to any:

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
3. plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization, including benefits required by state law, under an Employer sponsored short term disability program or under a salary continuation program;
4. mandatory "no-fault" automobile insurance plan;
5. disability benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act,that you, your spouse and children are eligible to receive because of your Disability; or
6. disability benefit from the Veteran's Administration, or any other foreign or domestic governmental agency:
 - a) that begins after you become Disabled; or
 - b) if you were receiving the benefit before becoming Disabled, the amount of any increase in the benefit that is attributed to your Disability.

Other Income Benefits also mean any payments that are made to you, your family, or to a third party on your behalf, pursuant to any:

1. disability benefit under the Employer's Retirement Plan;
2. permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges of such benefits;
3. portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
4. retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
 - a) you were receiving it prior to becoming Disabled; or
 - b) you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions; or

5. retirement benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act; the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act,

that you, your spouse and children receive because of your retirement, unless you were receiving them prior to becoming Disabled.

If you are paid Other Income Benefits in a lump sum or settlement, you must provide proof satisfactory to us of:

1. the amount attributed to loss of income; and
2. the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim. Please see the provision entitled, "What happens if benefits are overpaid?"

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1. takes effect after the date benefits become payable under this plan; and
2. is a general increase which applies to all persons who are entitled to such benefits.

Physician means a person who is:

1. a doctor of medicine, osteopathy, psychology or other healing art recognized by us;
2. licensed to practice in the state or jurisdiction where care is being given; and
3. practicing within the scope of that license.

Pre-disability Earnings means your Monthly Rate of Basic Earnings in effect on the day before you became Disabled.

Prior Plan means the long term disability insurance carried by the Employer on the day before the Plan Effective Date.

Recover or **Recovery** means that you are no longer Disabled and have returned to work with the Employer and premiums are being paid for you.

Regular Care of a Physician means you are attended by a Physician, who is not related to you:

1. with medical training and clinical experience suitable to treat your disabling condition; and
2. whose treatment is:
 - a) consistent with the diagnosis of the disabling condition;
 - b) according to guidelines established by medical, research and rehabilitative organizations; and
 - c) administered as often as needed,

to achieve the maximum medical improvement.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions. It does not include:

1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan or 403(b) plan.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

We, us or **our** means the Hartford Life and Accident Insurance Company.

You, your, Insured Person means the Insured Person to whom this Booklet-certificate is issued.

Your Occupation, if used in this Booklet-certificate, means your occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job you are performing for a specific employer or at a specific location.

With respect to Physicians:

Your Occupation - If You are a Physician or dentist, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.

STATUTORY PROVISIONS

CALIFORNIA

LONG TERM DISABILITY

Benefits

The definition section of the Survivor Income Benefit is amended as below:

"Spouse" means Your wife or husband who:

1. is mentally competent; and
2. was not legally separated from You at the time of Your death.

"Spouse" will include an individual who is 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.

Surviving Child(ren) includes children or Your California registered domestic partner.

NEW YORK

LONG TERM DISABILITY

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. Pre-existing Conditions Limitations

The following provision is added to the paragraph entitled "Are there any other limitations on coverage?" in the Pre-existing Conditions Limitations section appearing in your booklet.

However, if you become insured under the Group Insurance Policy and were covered under a group or blanket disability insurance plan or employer-provided disability benefit arrangement within 60 days of your effective date of coverage under this plan, any:

1. treatment-free period requirements; or
2. period of coverage requirements,

which were satisfied or partially satisfied under your previous coverage will be credited toward satisfaction of similar periods under this plan.

2. Continuity From a Prior Plan

The section entitled "Continuity From a Prior Plan" is amended to read as follows:

Is there continuity of coverage from a Prior Plan?

If you were:

1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

If you were covered under a Prior Plan within 60 days prior to the date your coverage under this plan takes effect, the Pre-Existing Conditions Limitation will cease to apply on the first to occur of the following dates:

1. the date your coverage under the plan takes effect, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the previous paragraph will be the lesser of:

1. the Monthly Benefit which was paid by the Prior Plan; or
2. the Monthly Benefit provided by this plan.

No payment shall be made after the earlier to occur of:

1. the date payments would have ceased under the Prior Plan; or
2. the date payments cease under this plan.

If you received Monthly Benefits for Disability under the Prior Plan, and:

1. you returned to work as an Active Full-time employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

Prior Plan, for the purpose of this provision, means an employer-provided disability benefit arrangement or group or blanket long term disability insurance carried by the Employer on the day before the Plan Effective Date.

NORTH CAROLINA

LONG TERM DISABILITY

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

1. Other Income Benefits Definition

With respect to the definition of Other Income Benefits which appears in the Definitions section of your Booklet-certificate, the following two items do not apply to you.

The item in the first paragraph of the definition of Other Income Benefits which reads we will offset with a "no-fault" automobile insurance plan does not apply to you.

The item in the second paragraph of the definition of Other Income Benefits which reads we will offset with a "portion of a settlement or judgement, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings" does not apply to you.

2. Regular Care and Attendance by a Physician

The following paragraph is added to the provision entitled "When do benefits become payable" appearing in the Disability Benefits section of your Booklet-certificate.

Regular care by a physician will cease to be required, if in the opinion of qualified medical professionals, further medical care and treatment would be of no benefit to you.

3. Subrogation

The provision entitled "What are our subrogation rights" appearing in the General Provisions section of your Booklet-certificate does not apply to you.

4. Notification

The following provision replaces the provision of the same title appearing in the General Provisions section of your Booklet-certificate.

When should we be notified of a claim?

You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include your name, your address and the Group Insurance Policy number. The notice should be sent to the Hartford Life and Accident Insurance Company, Hartford Plaza, Hartford, Connecticut 06115, or to the Employer, or an authorized agent of Hartford Life.

CAFETERIA PLAN ELECTION RESTRICTION

This Policy is a part of a Cafeteria Plan sponsored by your employer and governed by the requirements of Section 125 of the Internal Revenue Code. The rules of the Cafeteria Plan will supersede any provisions of the Policy which are in conflict with them.

By law, Cafeteria Plans are subject to the following restriction:

The benefits you elect during the enrollment period will remain in effect until the next enrollment period. Section 125 allows exception to this rule only in specified situations, including change in family status and commencement or termination of employment.

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.

1. Plan Name

UNIVERSITY HOSPITALS HEALTH SYSTEM GROUP BENEFIT PLAN.

2. Plan Number

LTD - 560

3. Employer/Plan Sponsor

UNIVERSITY HOSPITALS HEALTH SYSTEM
3605 Warrensville Center Road
Shaker Heights, OH 44122-5203

4. Employer Identification Number

34-0714775

5. Type of Plan

Welfare Benefit Plan providing Group Short Term Disability, Long Term Disability, Life, Supplemental Life and Accidental Death, Dismemberment and Loss of Sight Benefits.

6. Plan Administrator

UNIVERSITY HOSPITALS HEALTH SYSTEM
3605 Warrensville Center Road
Shaker Heights, OH 44122-5203

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

For the Plan

UNIVERSITY HOSPITALS HEALTH SYSTEM
3605 Warrensville Center Road
Shaker Heights, OH 44122-5203

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 Plan Year basis.
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11. **Labor Organizations**

As kept on file by the Employer.

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