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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Group Short Term Disability Benefits

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A note on capitalization in this benefits booklet:

Capitalization of the first letter of a word or phrase not normally capitalized according to the rules of standard punctuation (Weekly Earnings, for example) indicates a word or phrase that is defined in the DEFINITIONS section, or that refers back to an item found in the Schedule of 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 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.

Terence Shields, Secretary
Michael Concannon, Executive Vice 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: DUKE UNIVERSITY

Group Insurance Policy: GRH-043211

Plan Effective Date: January 1, 1998

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS AUGUST 1, 2014.

This plan of Short Term Disability Insurance provides you with short term income protection if you become Disabled from a covered accident, sickness or pregnancy.

Must you contribute toward the cost of coverage?
You must contribute toward the cost of coverage.

Who is eligible for coverage?
Eligible Class(es):
Class 2: Active Full-time Employees of Duke University Health Systems with less than 3 years of full continuous service or with an eligibility waiver from Duke University Health System

Class 3: Active Full-time Employees of Duke University Health Systems with 3 or more years of full continuous service or with an approved eligibility waiver from Duke University Health System.

Full-time Employees 30 hours or more weekly

The Weekly Benefit will be the lesser of:
• 60% of Your Weekly Earnings; or
• $2,885,

reduced by Other Income Benefits.

The Minimum Weekly Benefit will be $15.

The Maximum Duration of Benefits for a Disability is:
With respect to Class 2:
• when the Pre-existing Condition Limitation applies, 2 week(s) if caused by Accident or Sickness; otherwise;
• 22 week(s) if caused by Accident and 22 week(s) if caused by Sickness.

With respect to Class 3:
• when the Pre-existing Condition Limitation applies, 2 week(s) if caused by Accident or Sickness; otherwise
• 9 week(s) if caused by Accident and 9 week(s) if caused by Sickness.

Benefits Commence for Disability caused by:
• Accident: on the 29th day of Disability
• Sickness: on the 29th day of Disability

When will You become eligible? (Eligibility Waiting Period)
You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.
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?
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 31 days after becoming eligible, You must submit Evidence of Insurability satisfactory to us.

What is Evidence of Insurability?
If You are required to submit Evidence of Insurability, You must:
1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at Your own expense.

We will then determine if You are insurable under the plan.

WHEN DOES COVERAGE STARTS

When does Your coverage start?
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 first of the month following the date that MGIS receives your enrollment form, if you enroll within 31 days after the date you are eligible; or
3. the date we approve Your Evidence of Insurability, if you are required to submit Evidence of Insurability.

DEFERRED EFFECTIVE DATE

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 Your:
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, the effective date of the coverage or increase in coverage will be deferred until You have been Actively at Work for one full work-day.
CHANGES IN COVERAGE

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 Weekly 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 Your 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 Weekly 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, except that the limitations on increases stated in the Deferred Effective Date provision and the Pre-existing Conditions Limitation will apply.

BENEFITS

How do benefits become payable for Total Disability?
If, while covered under this Benefit, you become Totally Disabled, and furnish proof to us that you remain Totally Disabled, we will pay the Weekly Benefit shown in the Schedule of Insurance.

The amount of any Weekly Benefit payable shall be reduced by the total amount of all Other Income Benefits, including any amount for which you could collect but did not apply.

See the Schedule of Insurance for the Weekly Benefit, the Minimum Weekly Benefit, the Maximum Duration of Benefits, and when Benefits Commence.

No benefits will be payable unless you are under the care of a Physician other than yourself or a member of your immediate family.

A member of your immediate family is your spouse, father, mother, brother, sister, son or daughter.

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 value to you.

RESIDUAL DISABILITY BENEFITS

How are benefits paid for Residual Disability?
If while covered under this benefit, you become Disabled and work on a part-time or limited duty basis because you are Residually Disabled, the following calculation is used to determine your Weekly Benefit:

\[
\text{Weekly Benefit} = \left(\frac{(A - B)}{A}\right) \times C
\]

\[
\text{Where}
\]

A = Your pre-disability Weekly Earnings.
B = Your Current Weekly Earnings.
C = The Weekly Benefit payable if you were Totally Disabled.
Your Weekly Benefit, however, will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

If you are participating in a program of Rehabilitative Employment approved by us, your Weekly Benefit will be determined by the Rehabilitative Employment Benefit.

**How is a benefit calculated for a period of less than a week?**
If a Weekly Benefit is payable for less than a week, we will pay 1/7 of the Weekly Benefit for each day you were Disabled.

**When will benefit payments cease?**
Benefit payments will stop on the first to occur of:
1. the date you are no longer Disabled;
2. the date you fail to furnish proof that you continue to be Disabled;
3. the date you refuse to be examined, if we require an examination;
4. the last day benefits are payable according to the Maximum Duration of Benefits shown in the Schedule of Insurance; or
5. the date you die.

**RECURRENT DISABILITY**

**What happens to your benefits if you return to work as an Active Full-time Employee and then become Disabled again?**
If you return to work as an Active Full-time Employee for 20 consecutive days or more, any recurrence of a disability will be treated as a new Disability with respect to when Benefits Commence and the Maximum Duration of Benefits, as shown in the Schedule of Insurance.

If recurrent periods of Disability are:
1. due to the same or a related cause; and
2. separated by less than 20 consecutive days of work as an Active Full-time Employee,

they will be considered to be the same period of Disability.

**MULTIPLE CAUSES**

**How long will benefits be paid if a period of Disability is extended by another cause?**
If a period of Disability is extended by a new cause while weekly benefits are payable, weekly benefits will continue while you remain Disabled, subject to the following:
1. weekly benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2. the Exclusions and the Pre-existing Conditions Limitation will apply to the new cause of Disability.

**VOCATIONAL REHABILITATION**

**What is Vocational Rehabilitation?**
Vocational Rehabilitation means employment or services that prepare you, if Disabled, to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:
1. vocational testing;
2. vocational training;
3. work-place modification;
4. prosthesis; or
5. job placement.
REHABILITATIVE EMPLOYMENT

**Rehabilitative Employment** means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by us.

**Do earnings from Rehabilitative Employment affect the Weekly Benefit?**
If you are Disabled and are engaged in an approved program of Rehabilitative Employment, your Weekly Benefit will be:
1. the amount calculated for Total Disability; but
2. reduced by 50% of the income received from each week of such Rehabilitative Employment.

The sum of your Weekly Benefit and total income received under this provision may not exceed 100% of your pre-disability Weekly Earnings. If this sum exceeds your pre-disability Weekly Earnings, the Weekly Benefit paid by us will be reduced proportionately.

PRE-EXISTING CONDITIONS LIMITATIONS

**Are benefits limited for a Pre-existing Condition?**
The Maximum Duration of Benefits is limited as shown in the Schedule of Insurance. This limitation applies to any period of Disability that is due to, contributed to by, or results from a Pre-existing Condition, unless such Disability begins after the last day of 365 consecutive days during which you have been continuously insured under this plan.

**What is a Pre-existing Condition?**
A Pre-existing Condition is:
1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestation, symptom, finding, or aggravation related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which you received Medical Care during the 365 day 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.

EXCLUSIONS

**What Disabilities are not covered?**
The plan does not cover, and no benefit shall be paid for, any:
1. injury, sickness, Mental Illness, Substance Abuse, or pregnancy not being treated by a Physician or surgeon;
2. Disability caused or contributed to by war or act of war (declared or not);
3. Disability 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;
4. Disability caused or contributed to by an intentionally self-inflicted injury;
5. sickness or injury for which workers' compensation benefits are paid, or may be paid, if duly claimed; or
6. injury sustained as a result of doing any work for pay or profit for another employer.
If You are receiving, or are eligible to receive, benefits for a Disability under a prior plan of disability benefits that:
1. was sponsored by the Employer; and
2. was terminated on the day before the Effective Date of this plan,

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

**TERMINATION**

**When does Your insurance terminate?**
Your insurance will terminate on the earliest of:
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 on which You cease to be an Active Full-time Employee in an eligible class, including:
   a) temporary layoff;
   b) leave of absence; or
   c) work stoppage (including a strike or lockout); or
   d) the date Your Employer ceases to be a Participant Employer, if applicable.

**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 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) the date your Employer ceases to be a Participant Employer, if applicable.

If you choose not to continue your insurance by not paying premium during an approved family or medical leave of absence, upon your return to work, you will have 30 days to enroll for coverage. If you enroll, coverage will be reinstated with credit remaining toward the satisfaction of period of coverage requirements within the Pre-existing Conditions Limitation provision.

**May coverage be continued during a leave of absence?**
If you are granted a leave of absence, your Employer may continue your insurance for 12 month(s) following the month coverage would have terminated, subject to the following:
1. the leave authorization must be in writing, or must be documented as a leave for military purposes;
2. the required premium for you must be paid;
3. your benefit level, or the amount of earnings upon which your benefits 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) the date your Employer ceases to be a Participant Employer, if applicable.
If you choose not to continue your insurance by not paying premium during a leave of absence, other than an approved family or medical leave of absence, upon your return to work, you will be treated as a late enrollee. This means:
1. you must submit Evidence of Insurability satisfactory to The Hartford; and
2. any previous satisfaction of the period of coverage requirements within the Pre-existing Condition Limitation does not apply.

Does Your insurance continue while You are Disabled and no longer an Active Full-time Employee?
If You are no longer an Active Full-time Employee because You are Disabled, Your Short Term Disability Insurance will be continued:
1. while You remain Disabled;
2. without payment of premium after the date we receive written notice of claim; and
3. until the end of the period for which You are entitled to receive Short Term Disability Benefits.

After Short Term Disability benefit payments have ceased, Your insurance will be reinstated, provided:
1. You return to work for one full day as an Active Full-time Employee in an eligible class;
2. the Group Insurance Policy remains in force; and
3. the required premium is paid.

Do benefits continue if the Group Insurance Policy 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 disabling condition; 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 affect on our liability under this provision.

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 notice of claim by calling the special claims telephone number provided to employees. Such notice must be given on the fifth day of an absence due to the same or related Disability.

If notice cannot be given within that time, it must be given as soon as possible after that. Our representative will assist the caller through the process, gathering the appropriate information from You, Your Physician, and the Employer.

Are special forms required to file a claim?
Proof of Loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after We receive a notice of claim. If these forms are not sent within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

When must proof of loss be given?
Proof of loss must be provided to Us within 90 days after the start of the period for which We owe payment. If proof of loss is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof of loss within the required time; and
2. proof of loss is given as soon as reasonably possible; but
3. not later than 1 year after it is due, unless You are not legally competent.
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 reasonably 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.

When must proof of loss be given?
Written proof of Your Disability must be sent to us within 90 days after the start of the period for which we owe payment. After that, we may require further written proof that You are still Disabled. 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 reasonably possible; but

We have the right to require, as part of the proof of loss:
1. Your signed statement identifying all Other Income Benefits; and
2. proof satisfactory to us that You and Your dependents have duly applied for all Other Income Benefits which are available.

May additional proof be required?
We may have You examined to determine if You are Disabled. Any such 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.

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, 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?
If written proof of loss is furnished, accrued benefits will be paid at the end of each week that You are Disabled. If payment is due at the end of a claim, it will be paid as soon as the written 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. later than the expiration of:
   a) 3 years; or if longer, or
   b) the period of time stated in the applicable Statute of Limitations,
      after the time written proof of loss is required to be furnished according to the terms of the Group Insurance Policy.

**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:

**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. Such employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours for Full-time Employment shown in the Schedule of Insurance.

**Actively at Work**
You will be considered to be actively at work with the Employer on a day which is one of the 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 the Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

**Current Weekly Earnings** means the Weekly Earnings you receive from any employer or for any work while Disabled and eligible for Residual Disability benefits under this plan.

**Disability** means Total or Residual Disability.

**Disabled** means Totally or Residually Disabled.

**Employer** means the Policyholder.

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

**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, your family, or to a third party on your behalf. This includes the amount of any benefit for loss of income from:
1. the United States Social Security Act, the Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that you, your spouse or children are eligible to receive because of your Disability;
2. 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 long term disability program, including any sick leave, vacation pay, pay for personal time off or Kiel (donated paid time off) that you elect to take while You are Disabled, or under a salary continuation program;
3. the Veteran's Administration or any other foreign or domestic governmental agency for the same Disability;
4. any governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
5. individual insurance policy where the premium is wholly or partially paid by the Employer; or
6. any temporary or permanent disability benefits under a workers' compensation law, occupational disease law, or similar law.

Any general increase in benefits required by law that you are entitled to receive under any Federal Law will not reduce the Short Term Disability Benefit payable for a period of Total Disability that began prior to the date of such increase.

If you are paid Other Income Benefits in a lump sum, we will pro-rate the lump sum:
1. over the period of time it would have been paid if not paid in a lump sum; or
2. if such period of time cannot be determined, over a period of 260 weeks.

**Physician** means a practitioner of a healing art, which we are required by law to recognize, who is properly licensed, and practicing within the scope of that license.

**Prior Plan** means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

**Residual Disability or Residually Disabled** means that you are prevented by:
1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing some, but not all, of the essential duties of your or any occupation, and as a result, your Current Weekly Earnings are more than 20% but no more than 80% of your pre-disability Weekly Earnings.

**Sickness vs. Accident**
A Disability shall be deemed to be caused by sickness, and not by accident, if:
1. it is caused or contributed to by:
   a) any condition, disease or disorder of the body or mind;
   b) any infection, except a pus-forming infection of an accidental cut or wound;
   c) hernia of any type unless it is the immediate result of an accidental injury covered by this plan;
   d) any disease of the heart;
   e) Mental Illness;
   f) Substance Abuse;
   g) pregnancy;
   h) any medical treatment for items (a) through (g) above; or
2. it is caused directly or indirectly by accident, but commences more than 30 days after the date of the accident.

**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.

**Total Disability or Totally Disabled** means that you are prevented by:
1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing the essential duties of your occupation, and as a result, you are earning less than 20% of your pre-disability Weekly Earnings.

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

**Weekly Earnings** means your usual weekly rate of pay from the Employer, not counting:
1. commissions;
2. bonuses;
3. overtime pay; or
4. any other fringe benefit or extra compensation.

If you become Disabled, your Weekly Earnings will be the rate in effect on your last day as an Active Full-time Employee before becoming Totally Disabled.

**You or your** means the insured person to whom this Booklet-certificate is issued.
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Group Long Term Disability Benefits

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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.

Terence Shields, Secretary  
Michael Concannon, Executive Vice 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: DUKE UNIVERSITY

Group Insurance Policy: GLT-043211

Plan Effective Date: January 1, 1998

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF AUGUST 1, 2014.

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

Must you contribute toward the cost of coverage?
You must contribute toward the cost of coverage.

Who is eligible for coverage?
Eligible Class(es): Active Full-time Employees of Duke University Health System with less than 3 years of full-time continuous service or without eligibility waiver from Duke University Health System excluding faculty*, private diagnostic clinical faculty and staff, and house staff. *Full-time clinical associates and consulting associates are eligible for this benefit.

Full-time Employees: 30 hours or more weekly

Maximum Monthly Benefit: $12,500

The Minimum Monthly Benefit will be the greater of:

- $100; or
- 10% of the Monthly Benefit before the deduction of Other Income Benefits.

Benefit Percentage: 60%

When will You become eligible? (Eligibility Waiting Period)
You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

The Elimination Period is the period of time You must be Disabled before benefits become payable. It is the last to be satisfied of the following:

1. the first 6 consecutive month(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 benefits or salary continuation program.
MAXIMUM DURATION OF BENEFITS TABLE

<table>
<thead>
<tr>
<th>Age When Disabled</th>
<th>Benefits Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to Age 63</td>
<td>To Normal Retirement Age, or</td>
</tr>
<tr>
<td></td>
<td>for 48 months, if greater</td>
</tr>
<tr>
<td>Age 63</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>27 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>21 months</td>
</tr>
<tr>
<td>Age 69 and over</td>
<td>18 months</td>
</tr>
<tr>
<td></td>
<td>15 months</td>
</tr>
<tr>
<td></td>
<td>12 months</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65</td>
</tr>
<tr>
<td>1938</td>
<td>65 + 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 + 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 + 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 + 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 + 10 months</td>
</tr>
<tr>
<td>1943 thru 1954</td>
<td>66</td>
</tr>
<tr>
<td>1955</td>
<td>66 + 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 + 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 + 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 + 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 + 10 months</td>
</tr>
<tr>
<td>1960 or after</td>
<td>67</td>
</tr>
</tbody>
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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?
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 31 days after becoming eligible, you must submit Evidence of Insurability satisfactory to us.

**What is Evidence of Insurability?**
If You are required to submit Evidence of Insurability, You must:
1. complete and sign a health and medical history form provided by us;
2. submit to a medical examination, if requested;
3. provide any additional information and attending physicians' statements that we may require; and
4. furnish all such evidence at Your own expense.

We will then determine if You are insurable under the plan.

---

**WHEN COVERAGE STARTS**

When does Your coverage start?
If you must contribute toward 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 first of the month following the date that MGIS receives your enrollment form, if you enroll within 31 days after the date you are eligible; or
3. the date we approve your Evidence of Insurability, if you are required to submit Evidence of Insurability.

---

**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**

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.

Regular Care of 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.

When will benefit payments terminate?
We will terminate benefit payment on the first to occur of:
1. the date you are no longer Disabled;
2. the date you fail to furnish proof, when requested by us;
3. the date you are no longer under the Regular Care of a Physician, unless qualified medical professionals have determined that further medical care would be of no benefit to you;
4. the date you die;
5. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
6. the date no further benefits are payable under any provision in this plan that limits benefit duration;
7. the date your Current Monthly Earnings exceed 80% of your Indexed Pre-disability Earnings; or
8. 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 24 months for all such Disabilities during your lifetime.

RECURRENT DISABILITY

What happens if you return to work but become Disabled again?
Attempts to return to work as an Active Full-time Employee during the Elimination Period will not interrupt the Elimination Period, provided no more than 30 such return-days are taken.
Any day you were Actively at work 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 benefits calculated for Total Disability?**
If you are Disabled after the Elimination Period, your Monthly Benefits will be calculated as follows:
1. multiply your Monthly Rate of Basic Earnings by the Benefit Percentage shown in the Schedule of Insurance;
2. identify the Maximum Benefit shown in the Schedule of Insurance; and
3. compare the amounts determined in items (1) and (2) above and from the lesser amount subtract all Other Income Benefits.

The result is your Monthly Benefit. Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

**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.

**RETURN TO WORK INCENTIVE**

**How are benefits calculated if you return to limited duties during or following the Elimination Period?**
For Residual Disability, your Monthly Benefit for the 12 month period following the end of the Elimination Period will be calculated as follows:
1. determine the Monthly Benefit that would be paid if Totally Disabled and add to it the amount of any Current Monthly Earnings;
2. if the sum from above exceeds your level of Pre-disability Earnings, determine the amount of the excess by subtracting your Pre-disability Earnings from the sum;
3. your Monthly Benefit will be the Monthly Benefit that would be paid if Totally Disabled minus the amount of the excess determined in item (2) above.

During this 12 month period, the sum of your Monthly Benefit and your Current Monthly Earnings may provide an amount up to 100% of your Pre-disability Earnings.

**How are benefits calculated after the 12th Monthly Benefit has been paid?**
After you have received a Monthly Benefit for a 12 month period, and you continue to be Residually Disabled, the following calculation is used to determine your Monthly Benefit:

\[ \text{Monthly Benefit} = \frac{(A - B)}{A} \times C \]
Where

A = Your Indexed Pre-disability Earnings.
B = Your Current Monthly Earnings.
C = The Monthly Benefit payable if you were Totally Disabled.

Your Monthly Benefit, however, will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

VOCATIONAL REHABILITATION/
REHABILITATIVE EMPLOYMENT

What is Rehabilitation?

Vocational Rehabilitation means employment or services that prepare you, if Disabled, to resume gainful work. If you are Disabled, our Vocational Rehabilitative Services may help prepare you to resume gainful work.

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:
1. vocational testing;
2. vocational training;
3. work-place modification, to the extent not otherwise provided;
4. prosthesis; or
5. job placement.

Rehabilitative Employment means employment that is part of a program of Vocational Rehabilitation. Any program of Rehabilitative Employment must be approved, in writing, by us.

Do earnings from Rehabilitative Employment affect the Monthly Benefit?
If you are Disabled and are engaged in an approved program of Rehabilitative Employment, your Monthly Benefit will be:
1. the amount calculated for Total Disability; but
2. reduced by 50% of the income received from each month of such Rehabilitative Employment.

The sum of the resulting net Monthly Benefit and your total income received under Rehabilitative Employment may not exceed 100% of your Indexed Pre-disability Earnings. If it does, the Monthly Benefit will be reduced by the amount of excess.

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; or
3. your estate, if there is no surviving Spouse or Child.

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 Rate of Basic Earnings multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.
The following terms apply to this Benefit:
1. "Spouse" means your wife or husband who:
   a) is mentally competent; and
   b) was not legally separated from you at the time of your death; and
2. "Child" means your son or daughter under age 25 who is dependent on you for financial support.

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:
1. after the last day of 365 consecutive day(s) while insured during which you receive no medical care for the Pre-existing Condition; or
2. after the last day of 365 consecutive day(s) during which you have been continuously insured under this plan.

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 365 day 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;
2. use of drugs, medicines, medical services, supplies or equipment.

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.

May coverage be continued during a leave of absence?
If you are granted a leave of absence, the Employer may continue your insurance for 12 month(s) following the month coverage would have terminated subject to the following:
1. the leave authorization is in writing or is documented as a leave for military purposes;
2. the required premium must be paid;
3. your benefit level, or the amount of earnings upon which your benefits 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.

If you choose not to continue your insurance by not paying premium during a leave of absence, other than an approved family or medical leave of absence, upon your return to work, you will be treated as a late enrollee. This means:
1. you must submit Evidence of Insurability satisfactory to The Hartford; and
2. any previous satisfaction of the period of coverage requirements within the Pre-existing Condition Limitation does not apply.

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 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.

If you choose not to continue your insurance by not paying premium during an approved family or medical leave of absence, upon your return to work, you will have 30 days to enroll for coverage. If you enroll, coverage will be reinstated with credit remaining toward the satisfaction of any period of coverage requirements within the Pre-existing Conditions Limitations provision.

CONVERSION PRIVILEGE

Under what conditions can your Long Term Disability Coverage be converted to another plan?
If your insurance terminates because:
1. your employment ends for reason other than your retirement; or
2. you are no longer in an eligible class,

and if:
1. you have been continuously insured for at least 12 consecutive months under this plan or under this plan and the Prior Plan;
2. you are under the Limiting Age, if any is shown in the Schedule of Insurance;
3. a Disability is not preventing you from performing duties of Your Occupation;
4. the insurance for your class, or the plan has not terminated;
5. you are not eligible for coverage under the plan under another class; and
6. you are not eligible or covered for similar benefits under another group plan or an individual policy,

then you are eligible to enroll for personal insurance under another group policy called the Group Long Term Disability Conversion Policy.

Prior Plan, as used in this Conversion Privilege provision, means the plan of group long term disability insurance that was provided or sponsored by the Employer and terminated on the day before the Plan Effective Date.

How to convert
To obtain coverage under the Group Long Term Disability Conversion Policy, the following must be done within 31 days of the termination of group insurance:
1. a written enrollment request must be made to us; and
2. the required premium and enrollment fee for the conversion policy must be paid.

If the preceding conditions are met, we will issue to you a certificate of insurance under the Group Long Term Disability Conversion Policy. Such coverage will:
1. be issued without medical evidence of insurability;
2. be on one of the forms then being issued by us for conversion purposes; and
3. be effective on the day following the date your insurance under this plan terminates.
The coverage available under the conversion policy may differ from this plan. The terms of the Group Long Term Disability Conversion Policy, including:
1. the type and amount of coverage provided; and
2. the premium payable,

will be determined by the kinds of insurance being provided by the Group Long Term Disability Conversion Policy at the time such enrollment request is made.

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. 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.

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 of Loss 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.

When must one apply for Social Security Benefits?
You will be required to apply for Social Security disability benefits when the duration of Your Disability meets the minimum duration required to apply for such benefits. If the Social Security Administration denies Your eligibility for benefits, You will be required:
1. to follow the process established by the Social Security Administration to reconsider the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

What additional Proof of Loss are we entitled to?
We may have You examined to determine if You are Disabled. Any such examination will be:
1. at our expense; and
2. as reasonably required by us.

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. You must request a review upon written application within:
1. 180 days of receipt of claim denial if the claim requires a determination of disability, or
2. 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 happens if benefits are overpaid?
An overpayment occurs when it is determined that the total amount we have paid in benefits is more than the amount that was due to You under the plan. This includes, but is not limited to, overpayments resulting from:
1. retroactive awards of Other Income Benefits;
2. failure to report, or late notification to us of Other Income Benefits or earned income;
3. misstatement; or
4. an error we may make.

We have the right to recover from You any amount that is an overpayment of benefits under this plan. You must refund to us the overpaid amount. We may also, without forfeiting our right to collect an overpayment through any means legally available to us, recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the Minimum Monthly Benefit.

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, if used in this Booklet-certificate, means an occupation:
1. for which you are qualified by education, training or experience; and
2. that has an earnings potential greater than an amount equal to the product of your Indexed Pre-disability Earnings and the Benefit Percentage.

Current Monthly Earnings means the monthly earnings you receive from any employer or for any work, while Disabled and eligible for Residual Disability benefits under this plan.

Disabled or Disability means either Totally or Residually Disabled or Total or Residual Disability.

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. cannot 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 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, or 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 long term disability program, including any sick leave, vacation pay, pay for personal time off or Kiel (donated paid time off) that you elect to take while You are Disabled, or under a salary continuation program;
4. individual insurance policy where the premium is wholly or partially paid by the Employer;
5. 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;
6. 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.

**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 for such benefits;
3. 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;
4. 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 can not or do not provide this
information, we will assume the entire sum to be for loss of income, and the time period to be 12 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.

**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.

**Residual Disability or Residually Disabled** means you are prevented by:
1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy,

from performing some, but not all, the Essential Duties of Your or Any Occupation, and as a result your Current Monthly Earnings are at least 20%, but no more than 80% of your Indexed Pre-disability Earnings.

**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.

**Total Disability or Totally Disabled** means that:
1. during the Elimination Period; and
2. for the next 24 month(s), you are prevented by:
   a) accidental bodily injury;
   b) sickness;
   c) Mental Illness;
   d) Substance Abuse; or
   e) pregnancy,

from performing the Essential Duties of Your Occupation, and as a result you are earning less than 20% of your Pre-disability Earnings, unless engaged in a program of Rehabilitative Employment approved by us.

After that, you must be so prevented from performing the Essential Duties of Any Occupation for which you are qualified by education, training, or experience.

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

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

**You, your or 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.
STATUTORY PROVISIONS

MASSACHUSETTS

SHORT TERM DISABILITY

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

Continuation

The following is added to the Termination section of your Booklet-certificate.

Does your coverage continue if your employment terminates or you cease to be a member of an eligible class?
If your insurance terminates because your employment terminates or you cease to be a member of an eligible class, your insurance will automatically be continued until the end of a 31 day period from the date your insurance terminates or the date you become eligible for similar benefits under another group plan, whichever occurs first.

If your insurance terminates because your employment is terminated as a result of a plant closing or covered partial closing, your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:
1. ninety days from the date you were no longer eligible for coverage as an Active Full-time Employee;
2. the date you become eligible for similar benefits under another group plan;
3. the last day of the period for which required premium is made;
4. the date the Group Insurance Policy terminates; or
5. the date your Employer ceases to be a Participant Employer, if applicable.

Continued coverage is subject to all other applicable terms and conditions of the policy.

LONG TERM DISABILITY

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

Continuation

The following is added to the Termination section of your booklet.

Does your coverage continue if your employment terminates or you cease to be a member of an eligible class?
If your insurance terminates because your employment terminates or you cease to be a member of an eligible class, your insurance will automatically be continued until the end of a 31 day period from the date your insurance terminates or the date you become eligible for similar benefits under another group plan, whichever occurs first.

If your insurance terminates because your employment is terminated as a result of a plant closing or covered partial closing, your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:
1. 90 days from the date you were no longer eligible for coverage as an Active Full-time Employee;
2. the date you become eligible for similar benefits under another group plan;
3. the last day of the period for which required premium is made;
4. the date the Group Insurance Policy terminates;
5. the date your Employer ceases to be a Participant Employer, if applicable.

Continued coverage is subject to all other applicable terms and conditions of the policy.

MINNESOTA

LONG TERM DISABILITY

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

Survivor Income Benefit

The Spouse definition in the Survivor Income Benefit is amended to read as below:

“Spouse” means your spouse who:
   a) is mentally competent; and
   b) was not legally separated from you at the time of your death; and
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**
   
   Group Short Term Disability and Long Term Disability Plan for employees of DUKE UNIVERSITY.

2. **Plan Number**
   
   STD - 529
   LTD - 530

3. **Employer/Plan Sponsor**
   
   DUKE UNIVERSITY
   705 Broad Street
   Benefits Administration Dept.
   Durham, NC 27705

4. **Employer Identification Number**
   
   56-0532129

5. **Type of Plan**
   
   Welfare Benefit Plan providing Group Short Term Disability and Long Term Disability.

6. **Plan Administrator**
   
   DUKE UNIVERSITY
   705 Broad Street
   Benefits Administration Dept.
7. **Agent for Service of Legal Process**

For the Plan

DUKE UNIVERSITY  
705 Broad Street  
Benefits Administration Dept.  
Durham, NC 27705

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