YOUR BENEFIT PLAN

UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.

Basic Term Life, Basic Dependent Life, Basic Accidental Death and Dismemberment; Physicians

Questions about Your Coverage

In the event You have questions regarding any aspect of Your coverage, You should contact Your Employee Benefits Manager or You may write to us at:
The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call Us at: 1-800-523-2233
When calling, please give Us the following information:
1) the policy number; and
2) the name of the policyholder (employer or organization), as shown in Your Certificate of Insurance.

Or You may contact Our Sales Office:
200 Hopmeadow Street
Simsbury, CT 06089
TOLL FREE: 800 693-8567
FAX: 866 294-0942

If you have a complaint, and contacts between you and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require we provide you with additional contact information:

For Residents of:	Write	Telephone
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904	1(800) 852-5494
California	State of California Insurance Department Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013	1(800) 927-HELP
Illinois	Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767	Consumer Assistance: 1(866) 445-5364 Officer of Consumer Health Insurance: 1(877) 527-9431
Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1(800) 622-4461 1(317) 232-2395 (in the Indianapolis Area)
Virginia	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23209	1(800) 552-7945 (inside Virginia) 1(804) 371-9741 (outside Virginia)
Wisconsin	Office of the Commissioner of Insurance Complaints Department P.O. Box 7873 Madison, WI 53707-7873	1(800) 236-8517 (outside of Madison) 1(608) 266-0103 (in Madison) to request a complaint form.

The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read This certificate carefully.

Florida The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida.

Maryland The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all the benefits required by Maryland law.

Montana The benefits of the policy providing your coverage are governed primarily by the law of a state other than Montana.

Georgia

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

North Carolina

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

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

THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

Texas

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

You may also write to The Hartford at:
P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:
P.O. Box 149104

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una quaja al:

1-800-523-2233

Usted tambien puede escribir a The Hartford:
P.O. Box 2999
Hartford, CT 06104-2999

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104

Austin, TX 78714-9410
Fax # (512) 475-1771

PREMIUM OR CLAIM DISPUTES:
Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

Austin, TX 78714-9410
Fax # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:
Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

CERTIFICATE OF INSURANCE
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

Policyholder: University of Wisconsin Medical Foundation, Inc.
Policy Number: GL-036143
Policy Effective Date: June 1, 2006
Policy Anniversary Date: January 1, 2017

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

Signed for the Company

Richard G. Costello, *Secretary* **Thomas M. Marra, *President***

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

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SCHEDULE OF INSURANCE

AMENDMENT TO GROUP POLICY GL-036143 PROCESSED ON JULY 21, 2016. ANY CHANGES BETWEEN THIS POLICY AND THE PREVIOUSLY ISSUED POLICY ARE EFFECTIVE JUNE 22, 2016.

Cost of Coverage:

Non-Contributory Coverage:	Basic Life Insurance Accidental Death and Dismemberment
Contributory Coverage:	Basic Dependent Life Insurance Basic Spouse Life Insurance

Eligible Class(es) For Coverage: All Full-Time and Part-Time Active Employees who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal Employees:

Class 1: Physicians appointed with a 50% or greater appointment to the medical school

Full-time Employment: at least 30 hours weekly, excluding on-call time
Part-time Employment: at least 20 hours weekly, but less than 30 hours weekly, excluding on-call time

Eligibility Waiting Period for Coverage:
Original Employee Group
Class 1: On the later of:
1) the Policy Effective Date; or
2) Your date of hire.

New Employee Group:
Class 1: On your date of hire.

The time period(s) referenced above are continuous. Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-Time Active Employee with the Employer under the Prior Policy.

Life Insurance Benefit

Amount of Life Insurance

Basic Amount of Life Insurance

Maximum Amount
$500,000

Your Basic Amount of Life Insurance will never be greater than the amount of Life Insurance on which premium for You has been paid.

However, in no event will Your Basic Amount of Life Insurance be less than $10,000, if You are an Active Employee.

Dependent Life Insurance Benefit

Basic Amount of Dependent Life Insurance

	Maximum Amount
Spouse	$10,000
	Maximum Amount
Dependent Children: Age 15 day(s) but under age 19 year(s)	$5,000

Your Basic Dependent Amount of Life Insurance will never be greater than the amount of Life Insurance on which premium for Your Dependent has been paid.

The amount of Spouse Basic coverage may never exceed 50% of the Amount of Life Insurance in force for the Employee.

Spouse Only Life Insurance Benefit

	Guaranteed Issue Amount	Maximum Amount
Spouse	Increments of $50,000 to $50,000	Increments of $50,000 to $100,000

Your Basic Dependent Amount of Life Insurance will never be greater than the amount of Life Insurance on which premium for Your Dependent has been paid.

The amount of Spouse coverage may never exceed 50% of the Amount of Life Insurance in force for the Employee.

Accidental Death and Dismemberment Benefit

Basic Principal Sum

Maximum Amount
$500,000

Your Basic Accidental Death and Dismemberment Benefit will never be greater than the amount of Life Insurance on which premium for You has been paid.

Additional Accidental Death and Dismemberment Benefits:

Seat Belt and Air Bag Coverage
Seat Belt Benefit Amount:
Percentage of Basic AD&D Principal Sum: 100%
Maximum Amount: $50,000
Minimum Amount: $1,000

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

1) in accordance with the Conversion Right; or
2) under the Prior Policy.

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit and Principal Sum for You by the percentage indicated in the table below. This reduction will be effective on the January 1st following the date You attain the ages shown below. . The reduction will apply to the Amount of Life Insurance and Principal Sum in force immediately prior to the first reduction made.

Reductions also apply if:

1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 65.

Percentage by which original amount of coverage will be reduced.

With respect to the Basic Life Amount of Insurance, Accidental Death and Dismemberment Benefit and the Supplemental Spouse Dependent Life Insurance Benefit

Your Age	Your % Reduction
65	35%

70	55%
75	70%
80	80%
85	85%

The reduced amount of coverage will be rounded to the next higher multiple of $500, if not already a multiple of $500. An appropriate adjustment in premium will be made.

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become insured for Employee coverage; or
2) the date You acquire Your first Dependent.

No person may be covered:
1) as a Dependent and an Employee; or
2) as a Dependent of more than one Employee;

under The Policy.

Enrollment: *How do I enroll for coverage?*
For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your coverage and Your Dependent's coverage; and
2) deliver it to Your Employer.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your coverage and/or Your Dependent's coverage.

Any Enrollment may be subject to the Evidence of Insurability Requirements provision.

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability for initial coverage, if You:
1) enroll more than 31 days after the date You are first eligible to enroll;
2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage;
3) are enrolled for an Amount of Life Insurance greater than the Basic Guaranteed Issue Amount, regardless of when You enroll for coverage; or
4) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and

2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Dependent Evidence of Insurability Requirements*: When will my Dependents first be required to provide Evidence of Insurability?*

We require Evidence of Insurability, for initial coverage, if You:

1) enroll for Your Dependent coverage more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an Amount of Dependent Life Insurance greater than the Supplemental Dependent Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

However, no Evidence of Insurability will be required if:

1) the Amount of Life Insurance for Your Dependent Child is $15,000 or less; or
2) Your Dependents were previously covered for life insurance benefits, provided by Your Spouse's employer group plan, and
   a) Your Dependents have ceased to be covered under that plan due to Your Spouse's loss of employment or the cancellation of that group plan; and
   b) Your Dependents provide Us with proof of prior coverage, including the date of termination, when applying for Dependent coverage; and
   c) coverage with Us is requested within 31 days of Your Spouse's loss of coverage.

If Your Dependent Evidence of Insurability is not satisfactory to Us:

1) Your Dependent Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll;
2) Your Dependents will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

1) a completed and signed application approved by Us;
2) a medical examination;
3) attending Physicians' statement; and
4) any additional information We may require.

Evidence of Insurability will be furnished at Our expense except for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage under The Policy, as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Coverage, for which Evidence of Insurability is not required, will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible, if You enroll on or before that date; or
2) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

Continuity from a Prior Policy: *Is there Continuity of Coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if on the day before the Policy Effective Date, You were:

1) insured under the Prior Policy; and
2) Actively at Work or on an authorized family and medical leave;

but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance and accidental death and dismemberment principal sum:

1) You had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

1) the last day of a period of 12 consecutive months after the Policy Effective Date;
2) the date Your insurance terminates for any reason shown under the Termination provision;
3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Employee under The Policy.

Dependent Effective Date: *When does Dependent coverage start?*
Coverage for which Evidence of Insurability is not required, will start on the date You become eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

1) the date You become eligible for Dependent coverage; or
2) the date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become eligible.

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, is to become covered:

1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

he or she is:

1) confined in a hospital; or
2) Confined Elsewhere;

such coverage will not start until he or she:

1) is discharged from the hospital; or
2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Children.

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Dependent Continuity from a Prior Policy: *Is there Continuity of Coverage from a Prior Policy for my Dependents?*
If on the day before The Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the Amount of Life Insurance:

1) they had under the Prior Policy; or
2) shown in the Schedule of Insurance;

reduced by any coverage amount:

1) that is in force, paid or payable under the Prior Policy; or
2) that would have been so payable under the Prior Policy had timely election been made.

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

1) the date of the change;
2) the date requirements of the Deferred Effective Date provision are met; and
3) the date Evidence of Insurability is approved, if required.

Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself or my Dependents, must we provide Evidence of Insurability?*
If You or Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for an increase of more than one level; or
2) not already enrolled:
3) for Basic Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Basic Life Insurance; or
4) for Supplemental Life Insurance under The Policy, You and Your Dependents must provide Evidence of Insurability for any amount of Supplemental Life Insurance;
5) including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance they had in effect on the date immediately prior to the date You requested the increase will not change.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
3) the date the premium payment is due but not paid;
4) the date Your Employer terminates Your employment; or
5) the date You are no longer Actively at Work;

unless continued in accordance with any of the Continuation Provisions.

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:

1) the date Your coverage ends;
2) the date the required premium is due but not paid;

3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the continuation provisions.

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Coverage may not be continued under more than one Continuation Provision. The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions.

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

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 120 days after the date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 12 week(s) after. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Employer due to lack of work, Your coverage (including Dependent Life coverage) may be continued until the last day of the month following the month in which the layoff commenced. If the lay-off becomes permanent, this continuation will cease immediately.

Status Change: If You are:

1) employed by the Policyholder; and
2) no longer in an Eligible Class due to a reduction in the number of scheduled hours You work;

Your coverage (including Dependent Life coverage) may be continued until the last day of the third consecutive month after the month in which Your scheduled hours were reduced.

Disability Insurance: If You are working for the Policyholder and:

1) are covered by;
2) are receiving benefits under; and
3) are earning at least 20%, but less than 80%, of Your Pre-disability Earnings, as defined by;

a Group Long Term Disability Insurance Policy, issued by Us to Your Employer, Your coverage (including Dependent Life coverage) may be continued.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:

1) for a period of 12 consecutive month(s) from the date You were last Actively at Work; or
2) if such absence results in a leave of absence in accordance with state and/or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive month(s).

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence terminates prior to the agreed upon date, this continuation will cease immediately.

Sabbatical: With respect to Class 1, if You are on a documented sabbatical, Your coverage (including Dependent Life coverage) may be continued until the last day of the 12th month following the date the sabbatical commenced. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately. Coverage continuation must be pre-approved by Us if the sabbatical leave is greater than 30 days.

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Children with disabilities be continued?*
If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

1) age 19 or older; and
2) disabled; and
3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
2) such Dependent Child(ren) must have become disabled before attaining age 19.

Coverage under The Policy will continue as long as:

1) You remain insured;
2) the child continues to meet the required conditions; and
3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Children will be available.

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

Waiver of Premium: *Does coverage continue if I am Disabled?*
Waiver of Premium is a provision which allows You to continue Your and Your Dependent's Life Insurance coverage without paying premium, while You are Disabled and qualify for Waiver of Premium.

If You qualify for Waiver of Premium, the amount of continued coverage:

1) will be the amount in force on the date You cease to be an Active Employee;
2) will be subject to any reductions provided by The Policy; and
3) will not increase.

Eligible Coverages: *What coverages are eligible under this provision?*
This provision applies only to:

1) Your Life Insurance; and
2) Dependent Life Insurance.

Disabled: *What does Disabled mean?*
Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:

1) education;
2) training; or
3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 12 months or less.

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*
To qualify for Waiver of Premium You must:

1) be covered under The Policy when You become Disabled;
2) be Disabled and provide Proof of Loss that You have been Disabled for 3 consecutive months, starting on the date You were last Actively at Work; and
3) provide such proof within one year of Your last day of work as an Active Employee.

In any event, You must have been Actively at Work under The Policy to qualify for Waiver of Premium.

When Premiums are Waived: *When will premiums be waived?*
If We approve Waiver of Premium, We will notify You of the date We will begin to waive premium. In any case, We will not waive premiums for the first 3 month(s) You are Disabled. We have the right to:

1) require Proof of Loss that You are Disabled; and
2) have You examined at reasonable intervals during the first 2 years after receiving initial Proof of Loss, but not more than once a year after that.

If You fail to submit any required Proof of Loss or refuse to be examined as required by Us, then Waiver of Premium ceases.

However, if We deny Your application for Waiver of Premium, You may be eligible to convert coverage in accordance with the Conversion Right for You and Your Dependents.

If You cease to be Disabled and return to work for a total of 5 days or less during the first 3 month(s) that You are Disabled, the 3 month(s) waiting period will not be interrupted. Except for the 5 days or less that You worked, You must be Disabled by the same condition for the total 3 month(s) period. If You return to work for more than 5 days, You must satisfy a new waiting period.

Benefit Payable before Approval of Waiver of Premium: *What if I die or my Dependent dies before I qualify for Waiver of Premium?*
If You or Your Dependent die within one year of Your last day of work as an Active Employee, but before You qualify for Waiver of Premium, We will pay the Amount of Life Insurance which is in force for the deceased person provided:

1) You were continuously Disabled;
2) the Disability lasted or would have lasted 3 month(s) or more; and
3) premiums had been paid for coverage.

Waiver Ceases: *When will Waiver of Premium cease?*
*We will waive premium payments and continue Your cove*rage, while You remain Disabled, until the earlier of:

1) the date You attain Normal Retirement Age if Disabled prior to age 60; or
2) 5 years after the date You became Disabled, if You became Disabled on or after age 60.

We will waive premium payments for Your Dependent Life Insurance and continue such coverage, while You remain Disabled, until the earliest of the date:

1) You die;
2) You no longer qualify for Waiver of Premium;
3) The Policy terminates;
4) Your Dependents are no longer in an Eligible Class, or Dependent coverage is no longer offered; or
5) Your Dependent no longer meets the definition of Dependent.

What happens when Waiver of Premium ceases?
When the Waiver of Premium ceases:

1) if You return to work in an Eligible Class, as an Active Employee, then You may again be eligible for coverage for Yourself and Your Dependents as long as premiums are paid when due; or
2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right for You and Your Dependents if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right.

Effect of Policy Termination: *What happens to the Waiver of Premium if The Policy terminates?*
If The Policy terminates before You qualify for Waiver of Premium:

1) You may be eligible to exercise the Conversion Right, provided You do so within the time limits described in such provision; and
2) You may still be approved for Waiver of Premium if You qualify.

If The Policy terminates after You qualify for Waiver of Premium:

1) Your Dependent coverage will terminate; and
2) Your coverage under the terms of this provision will not be affected.

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*
If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

Accelerated Benefit: *What is the benefit?*

In the event that You or Your Dependents are diagnosed as Terminally Ill while the Terminally Ill person is:

1) covered under The Policy for an Amount of Life Insurance of at least $10,000; and
2) is under age 60;

We will pay the Accelerated Benefit amount as shown below, provided We receive proof of such Terminal Illness.

You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit.

You may request a minimum Accelerated Benefit amount of $3,000, and a maximum of $500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of $20,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from $3,000 to $16,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only $3,000 now, You cannot request the additional $13,000 in the future.

A person who submits proof satisfactory to Us of his or her Terminal Illness will also meet the definition of Disabled for Waiver of Premium.

In the event:

1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an Assignment of rights and interest with respect to Your or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependents refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

No Longer Terminally Ill: *What happens to my coverage if I am no longer Terminally Ill or my Dependent is no longer Terminally Ill?*
If You or Your Dependents are diagnosed by a Physician as no longer Terminally Ill and:

1) return to an Eligible Class, coverage will remain in force, provided premium is paid;
2) do not return to an Eligible Class, but You continue to meet the definition of Disabled, coverage will remain in force, subject to the Waiver of Premium provision; or
3) are not in an Eligible Class, but You do not continue to meet the definition of Disabled, coverage will end and You may be eligible to exercise the Conversion Right, if You do so within the time limits described in such provision.

In any event, the amount of coverage will be reduced by the Accelerated Benefit paid.

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*
If Life Insurance coverage or any portion of it under The Policy ends for any reason, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for:

1) the Accidental Death and Dismemberment Benefits; or
2) any Amount of Life Insurance for which You or Your Dependents were not eligible and covered;

under The Policy.

If coverage under The Policy ends because:

1) The Policy is terminated; or
2) Coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

1) $10,000; or
2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

Conversion: *How do I convert my coverage or coverage for my Dependents?*
To convert Your coverage or coverage for Your Dependents, You must:

1) complete a Notice of Conversion Right form; and
2) have your Employer sign the form.

The Insurer must receive this within:

1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:

1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*
The Conversion Policy will:

1) be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:

1) in accordance with the Waiver of Premium provision; or
2) under a certificate of insurance issued in accordance with the Portability provision; or
3) in accordance with the Continuation Provisions;

until such coverage ends.

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*
We will pay the deceased person’s Amount of Life Insurance You would have had the right to apply for under this provision if:

1) coverage under The Policy terminates;
2) You or Your Dependent die within 31 days of date coverage terminates; and
3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

Accidental Death and Dismemberment Benefit: *When is the Accidental Death and Dismemberment Benefit payable?*
If You sustain an Injury which results in any of the following Losses within 365 days of the date of accident, We will pay Your amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss after We receive Proof of Loss, in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance.

For Loss of:	**Benefit:**
Life	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing in Both Ears	Principal Sum
Either Hand or Foot and Sight of One Eye	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half of Principal Sum
Either Hand or Foot	One-Half of Principal Sum
Sight of One Eye	One-Half of Principal Sum
Speech or Hearing in Both Ears	One-Half of Principal Sum
Movement of One Limb (Uniplegia)	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter of Principal Sum

Loss means with regard to:
1) hands and feet, actual severance through or above wrist or ankle joints;
2) sight, speech and hearing, entire and irrecoverable loss thereof;
3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
4) movement, complete and irreversible paralysis of such limbs.

Seat Belt: *When is the Seat Belt Benefit payable?*
If You sustain an Injury which results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt if the Injury occurred while You were:
1) a passenger riding in; or
2) the licensed operator of;

a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:
1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
2) according to the General Provisions of The Policy.

The Seat Belt Benefit is the lesser of:
1) an amount resulting from multiplying Your amount of Principal Sum by the Seat Belt Benefit Percentage; or
2) the Maximum Amount for this Benefit.

If it cannot be determined that You were wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only**,** means the unintentional collision of a Motor Vehicle during which You were wearing a Seat Belt.

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

The Seat Belt Benefit will not be payable if You are operating the Motor Vehicle at the time of Injury while:
1) Intoxicated; or

2) taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician.

Intoxicated means:
1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

EXCLUSIONS

Exclusions: (applicable to all benefits except the Life Insurance, Accelerated Benefit): *What losses are not covered?*
The Policy does not cover any loss caused or contributed to by:
1) intentionally self-inflicted Injury;
2) suicide or attempted suicide, whether sane or insane;
3) war or act of war, whether declared or not;
4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
6) Injury sustained while committing or attempting to commit a felony; or
7) Injury sustained while Intoxicated.

Intoxicated means:
1) the blood alcohol content;
2) the results of other means of testing blood alcohol level; or
3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*
You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after:
1) the date of death; or
2) the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

Claim Forms: *Are special forms required to file a claim?*
We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include, but is not limited to, the following:
1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) documentation of:
   a) the date Your Disability began;

b) the cause of Your Disability; and
c) the prognosis of Your Disability;

6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
9) Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss:

1) with respect to the Life Insurance Benefits, should be sent within 90 day(s); and
2) with respect to the Accidental Death and Dismemberment Benefits, must be sent within 90 day(s);

after the loss. All Proof of Loss should be sent to Us. However, all claims should be submitted to Us within 90 day(s) of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:

1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
2) to have an autopsy performed in case of death where it is not forbidden by law.

Claim Payment: *When are benefit payments issued?*
When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 day(s) after such Proof of Loss is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits and benefits for loss of life under the Accidental Death and Dismemberment Benefits will be paid in accordance with the life insurance Beneficiary Designation.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1) the executors or administrators of Your estate; or
2) all to Your surviving spouse; or
3) if Your spouse does not survive You, in equal shares to Your surviving Children; or
4) if no child survives You, in equal shares to Your surviving parents.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

1) $200 at Your death; and
2) monthly installments of not more than $200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving Spouse or the executor or administrator of Your estate.

If benefits are payable and meet Our guidelines, then We may pay benefits into a draft book account (checking account) which will be owned by:

1) You, if living; or
2) Your beneficiary, in the event of Your death.

The account owner may elect a lump sum payment by writing a check for the full amount in the account. However, an account will not be established for:
1) a benefit payable to Your estate; or
2) an Accidental Death and Dismemberment Principal Sum that is less than $10,000.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent,

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

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

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

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

Claim Denial: *What notification will my Beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your Beneficiary will be furnished with written notification of the decision. This written notification will:
1) give the specific reason(s) for the denial;
2) make specific reference to the provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do my Beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:
1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

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

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Incontestability: *When can The Policy be contested?*
Except for non-payment of premiums, the Life Insurance Benefit of The Policy cannot be contested after two years from the Policy Effective Date. This provision does not apply to the Accidental Death and Dismemberment benefit(s).

In the absence of Insurance Fraud, 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.

No statement made relating to Your Dependents being insurable will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during the Dependent's lifetime. In order to be used, the statement must be in writing and signed by You or Your representative.

Assignment: *Are there any rights of assignment?*
Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign Your rights and interest under The Policy including, but not limited to the following:

1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:

1) sooner than 60 days after the date Proof of Loss is furnished; or
2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

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

Insurance Fraud: *How does the Company deal with fraud?*
Insurance fraud occurs when You, Your Dependents and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents 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, Your Dependents and/or Your Employer perpetrate insurance fraud.

Misstatements: *What happens if facts are misstated?*
If material facts about You or Your Dependents were not stated accurately:

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

DEFINITIONS

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

1) in the usual way; and
2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Bonuses means the average of monetary bonuses You received over:

1) the 1 year period immediately prior to the date You were last Actively at Work; or
2) the total period of time You worked for an employer, if less than the above period.

Commissions means the average of monetary commissions You received over:

1) the 1 year period immediately prior to the date You were last Actively at Work; or
2) the total period of time You worked for an employer, if less than the above period.

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:

1) Your unmarried children, stepchildren, legally adopted children; or
2) any other children or domestic partnership who:
   a) live with You in a regular parent-child relationship; and/or
   b) You claimed as a dependent on Your last filed federal income tax return;

provided such children are primarily dependent upon You for financial support and maintenance and are:

1) at least 15 days old but under age 19;
2) age 19, but under age 25, and in full-time attendance (at least 12 course credit hours per semester) at an accredited institution of learning. If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student continues to qualify as a Dependent; or
3) age 19 or older and disabled. Such children must have become disabled before attaining age 19. You must submit proof, satisfactory to Us, of such children's disability.

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States, its territories and protectorates. Any person who is in full-time military service cannot be a dependent.

Earnings means, Your regular annual rate of pay, in effect on the date You were last Actively at Work, based on Your Statement of Wages Earned and Taxes Withheld (Form W-2) for:

1) the 1 year period immediately prior to the date You were last Actively at Work; or
2) the total number of calendar months You worked for Your Employer, if less than the above period;

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,

for the same period as above.

Employer means the Policyholder.

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

Injury means bodily injury resulting:

1) directly from an accident; and
2) independently of all other causes;

which occurs while You are covered under The Policy.

Loss resulting from:

1) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

Motor Vehicle means a self-propelled, four (4) or more wheeled:

1) private passenger: car, station wagon, van or sport utility vehicle;
2) motor home or camper; or
3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	**Normal Retirement Age**	**Year of Birth**	**Normal Retirement Age**
1937 or before	65	1955	66 + 2 months

1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

Physician means a person who is:

1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Prior Policy means the group life insurance Policy carried by Your Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or someone in a similar relationship in law to You.

Spouse means Your spouse who is not legally separated or divorced from You.
Spouse will include Your domestic partner, provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

The Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page.

We, Us or Our means the insurance company named on the face page of The Policy.

You or Your means the person to whom this certificate is issued.

AMENDATORY RIDER

This rider is attached to all certificates given in connection with The Policy and is effective on The Policy Effective Date.

This rider is intended to amend Your certificate, as indicated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your certificate will affect Your coverage. In addition, any reference made herein to Dependent coverage will only apply if Dependent coverage is provided in Your certificate.

For Colorado residents, the **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

For Louisiana residents:

1) The definition of **Dependent Child(ren)** is replaced by the following:
   Dependent Child(ren) means:
   1) Your unmarried children, stepchildren, legally adopted children;
   2) unmarried child who is placed in your home pursuant to an adoption placement agreement; executed with a licensed adoption agency (from the date of placement in your home);
   3) an unmarried child who is placed in your home following execution of an act of voluntary surrender (as of the date on which the act of voluntary surrender becomes irrevocable);
   4) your unmarried grandchild who is in your legal custody; or
   5) any other children related to You by blood or marriage who live with You in a regular parent-child relationship;

   provided such children are primarily dependent upon You for financial support and maintenance and are:
   1) from live birth to age 21 years;
   2) age 21, but under age 24, and in full-time attendance at an accredited institution of learning. If a student is attending a Louisiana vocational, technical, vocational-technical, or trade school or institute on a full-time basis, as defined by the institution, then we will consider the student to have satisfied the requirements of full-time attendance for The Policy;
   3) Coverage will be continued for a child up to age 24 who is deemed to be unable to attend school full-time due to a mental or nervous condition, problem or disorder; or
   4) age 21 or older and disabled. Such children must have become disabled before attaining age 21. You must submit proof, satisfactory to Us, of such children's disability.
2) The definition of **Dependent** is replaced by the following:
   Dependent means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States, its territories and protectorates. Any person who is in full-time military service cannot be a dependent, unless that person is subsequently called to military service and any required premium is paid.
3) Any and all references to Domestic Partners are hereby deleted.
4) The age limit stated in the **Continuation for Dependent Children with Disabilities** provision is increased to 21, if less than 21.
5) The following provision is added to the **Period of Coverage** provisions:
   Reinstatement after Military Service: If:
   1) Your coverage terminates because You enter active military service; and
   2) You are rehired within 12 months of the date Your coverage terminated/within 12 months of the date You return from active military service;

   then coverage for You and Your previously covered Dependent Spouse/Dependents may be reinstated, provided You request such reinstatement within 31 days of the date You return to work. The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage terminated; and
   2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
   3) be subject to all the terms and provisions of The Policy.
6) The last paragraph of the **Claims to be Paid** provision is replaced by the following:

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment because of expenses from Your funeral or other expenses incident to Your last illness or death. Payment to any person, as shown above, will release Us from liability for the amount paid.

7) The exclusion for the **Seatbelt and Air Bag** benefit is replace by the following:
   The Seat Belt and Air Bag Benefit will not be payable if the injured person is operating the Motor Vehicle at the time of Injury while:
   1) Intoxicated; or
   2) under the influence of narcotics, unless administered on the advice of a physician.
8) Exclusion 7 in the Accidental Death and Dismemberment **Exclusions** is replaced by the following:
   7. Injury sustained while under the influence of narcotics, unless administered on the advice of a physician;

For Minnesota residents:

1) The term "granted military leave of absence" in the Military Leave of Absence portion of the **Continuation Provisions** section, is amended to "documented military leave of absence."
2) the 7th paragraph of the **Accelerated Benefit** provision is deleted.
3) the 2nd, 3rd and 4th paragraphs of the **Conversion Right** provision are deleted.
4) The first sentence of the 5th paragraph of the **Claims to be Paid** provision is amended as follows:
   If benefits are payable and are greater than $15,000, then You or Your beneficiary may request that We pay benefits into a draft book account (checking account) which will be owned by:
   1) You, if living; or
   2) Your beneficiary, in the event of Your death.

For Missouri residents:

1) The time periods stated in the **Conditions for Qualification** and the **Benefit Payable before Approval of Waiver of Premium** provisions are changed to 180 days, if greater than 180 days.
2) The following language is added to the **When Premiums are Waived** provision:
   If Waiver of Premium is approved, it will be retroactive to the date the disability began. Premiums will be waived retrospectively once You have completed the 180 day waiting period.
3) The first sentence of the **Suicide** provision is replaced by the following:
   If You or Your Dependent commit suicide, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death if We can show that the deceased person intended suicide when coverage was elected.

For Montana residents:

1) The time period stated in the **Conversion Right** provision is changed to 3 years, if greater than 3 years.
2) The dollar amount stated in the **Conversion Right** provision is changed to $10,000, if less than $10,000.
3) The 2nd paragraph of the **Conversion Policy Provisions** is deleted.
4) The dollar amount stated in the second paragraph of the **Claims to be Paid** provision is changed to $500, if not $500.
5) The following provision is added to the **Claims to be Paid** provision.
   Payable Interest: *Is interest payable on death claims?*
   Claims payable for loss of life will be paid within 60 days of the date due proof is received. If the claim is paid more than 30 days after the date due proof is received, the amount payable will include interest. Interest will be paid at the discount rate, on 90-day commercial paper, in effect at the Federal Reserve Bank in the Ninth Federal Reserve District on the date due proof is received.

For New Hampshire residents:

1) The Waiver of Premium and Disability Extension provision or the Disability Extension provision is deleted
2) The following is added to the end of the first paragraph of the Conversion provision:
   The Notice of Conversion Right form will be mailed to You within 15 days after the Policy ceases. If notice is given more than 15 days after the Policy ceases, the time You have to convert will be extended for 15 days from the date notice was given.
3) The last sentence of the second paragraph of the Conversion provision is replaced by the following:
   However, unless you did not have notice, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.
4) Item #3 in the second paragraph of the Sending Proof of Loss provision is deleted.
5) The dollar amount stated in the second paragraph of the Claims to be Paid provision is changed to $250, if not $250.

For North Dakota residents, the **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

For South Carolina residents:

1) The following is added to the **Physical Examinations and Autopsy** provision: "Such autopsy must take place in the state of South Carolina."
2) The dollar amount stated in the second paragraph of the **Claims to be Paid** provision is changed to $2,000, if not $2,000.

For Vermont residents:

Purpose: This endorsement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.
5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

Cautionary Disclosure: THIS RIDER IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE RIDER. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS RIDER. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.

For Washington residents:

1) The **Suicide** provision is deleted in its entirety.
2) The following is added to the **No Longer Terminally Ill provision:**

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

For Wisconsin residents:

1) The dollar amount stated in the **Conversion Right** provision is changed to $5,000, if not $5,000.
2) The dollar amounts stated in the second paragraph and the last paragraph of the **Claims to be Paid** provision are changed to $1,000, if not $1,000.

In all other respects, the Policy and certificates remain the same.

Signed for Hartford Life and Accident Insurance Company.

Richard G. Costello, *Secretary* **Thomas M. Marra, *President***

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

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

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

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

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1. **Plan Name**

UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION LIFE AND DISABILITY INSURANCE PLAN.

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2. **Plan Number**

LIFE - 501

ADD - 501

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3. **Employer/Plan Sponsor**

UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.
301 S. Westfield Road
Suite 200
Madison, WI 53717

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4. **Employer Identification Number**

39-1824445

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5. **Type of Plan**

Welfare Benefit Plan providing Group Basic Term Life, Basic Dependent Life, Basic Accidental Death and Dismemberment.

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6. **Plan Administrator**

UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.
301 S. Westfield Road
Suite 200
Madison, WI 53717

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

For the Plan

UNIVERSITY OF WISCONSIN MEDICAL FOUNDATION, INC.
301 S. Westfield Road
Suite 200
Madison, WI 53717

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.

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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.

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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.

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

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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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
Simsbury, Connecticut
Member of The Hartford Insurance Group