
**GROUP
BENEFIT
PLAN**

LEHIGH UNIVERSITY

**Long Term Disability, Life, Supplemental Life and
Supplemental Dependent Life**

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Group Long Term Disability Benefits

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PS-M-90



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

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

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

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

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

according to the terms of the Policy.

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

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

Richard G. Costello, Secretary

Thomas M. Marra, President

SCHEDULE OF INSURANCE

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

Policyholder: LEHIGH UNIVERSITY

Group Insurance Policy: GLT-207718

Plan Effective Date: January 1, 1998*

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF JULY 1, 2003.

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

Must you contribute toward the cost of coverage?

You do not contribute toward the cost of coverage.

Who is eligible for coverage?

Eligible Class(es): All Active Salaried Full-time Faculty and Staff as follows:

Class 1 Employees with a LTD base salary of \$60,000 or more annually.

Class 2 Employees with a LTD base salary of \$30,000 - \$59,999 annually.

Class 3 Employees with a LTD base salary of less than \$30,000 annually.

Maximum Monthly Benefit: \$15,000

Minimum Monthly Benefit: \$50

Benefit Percentage 66 2/3%

When will You become eligible? (Eligibility Waiting Period)

You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

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

1. the first 180 consecutive day(s) of any one period of Disability, (the Elimination Period must be completed within 210 consecutive days); or
2. with the exception of benefits required by state law, the expiration of any Employer-sponsored short term disability benefits or salary continuation program.

MAXIMUM DURATION OF BENEFITS TABLE

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

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

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

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

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?

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

When will you become eligible?

You will become eligible for coverage on either:

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

See the Schedule of Insurance for the Eligibility Waiting Period.

How do you enroll?

Eligible Persons will be enrolled automatically by the Employer.

WHEN COVERAGE STARTS

When does your coverage start?

Your coverage will start on the date you become eligible.

DEFERRED EFFECTIVE DATE

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

If you are absent from work due to:

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

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

CHANGES IN COVERAGE

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

Your coverage may increase or decrease only on January 1 or July 1 when there is a change in your Monthly Rate of Basic Earnings. However, no increase in coverage will be effective unless on that date you:

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

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

What happens if the Employer changes the plan?

Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change; however, any increase in coverage will be subject to the Deferred Effective Date provision.

BENEFITS

When do benefits become payable?

You will be paid a monthly benefit if:

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

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

When will benefit payments terminate?

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

1. the date you are no longer Disabled;
2. the date you fail to furnish proof that you continue to be Disabled, when requested by us;
3. the date you are no longer under the Regular Care of a Physician, or refuse our request that you submit to an examination by a Physician;
4. the date you die;
5. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
6. the date your Current Monthly Earnings exceed 80% of your Indexed Pre-disability Earnings.

SUBSTANCE ABUSE BENEFITS

With respect to Alcoholism and/or Drug Addiction, no amount of insurance will be payable for any period while you are not being actively supervised and receiving continuous treatment from a Rehabilitation Center or a designated institution approved for such treatment by an appropriate body in the governing jurisdiction or, if none exists, by The Hartford.

RECURRENT DISABILITY

What happens if you return to work but become Disabled again?

Attempts to return to work as an Active Full-time Employee during the Elimination Period will not interrupt the Elimination Period, subject to one limitation – for an Elimination Period of 180 or more days, up to 30 such return-days are allowed.

Any day you were Actively at work will not count towards the Elimination Period.

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

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

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

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

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

CALCULATION OF MONTHLY BENEFIT

How are benefits calculated for Total Disability?

If you are Disabled after the Elimination Period, your Monthly Benefits will be calculated as follows:

1. multiply your Monthly Rate of Basic Earnings by the Benefit Percentage shown in the Schedule of Insurance;
2. identify the Maximum Benefit shown in the Schedule of Insurance; and
3. compare the amounts determined in items (1) and (2) above and from the lesser amount subtract all Other Income Benefits.

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

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

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

RESIDUAL DISABILITY BENEFIT

How are benefits calculated for Residual Disability?

If you are able to perform some but not all the Essential Duties of Your or Any Occupation, and are Residually Disabled, the following calculation is used to determine your Monthly Benefit:

$$\text{Monthly Benefit} = ((\mathbf{A} - \mathbf{B}) / \mathbf{A}) \times \mathbf{C}$$

Where

A = Your Indexed Pre-disability Earnings.

B = Your Current Monthly Earnings.

C = The Monthly Benefit payable if you were Totally Disabled.

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

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

**VOCATIONAL REHABILITATION/
REHABILITATIVE EMPLOYMENT**

What is Rehabilitation?

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

Our Vocational Rehabilitative Services include, when appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. work-place modification, to the extent not otherwise provided;
4. prosthesis; or
5. job placement.

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

Do earnings from Rehabilitative Employment affect the Monthly Benefit?

If you are Disabled and are engaged in an approved program of Rehabilitative Employment, your Monthly Benefit will be:

1. the amount calculated for Total Disability; but
2. reduced by 50% of the income received from each month of such Rehabilitative Employment.

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

COST-OF-LIVING ADJUSTMENT

How do benefits keep abreast of inflation?

Your Monthly Benefit for Total Disability may increase in accordance with the Cost-of-Living formula described below. The Cost-of-Living Adjustment is made each year on January 1st. Your Monthly Benefit may increase under this formula provided you:

1. have been Totally Disabled for 12 consecutive months; and
2. are receiving benefits when the Cost-of-Living Adjustment is made.

What is the Cost-of-Living Formula?

To apply the Cost-of-Living Formula:

1. multiply 3% times the Monthly Benefit for Total Disability being received; and
2. add the resulting amount to your Monthly Benefit.

How long will Cost-of-Living Adjustments continue?

No Cost-of-Living Adjustment will be made after you cease to be Totally Disabled.

SURVIVOR INCOME BENEFIT

Will your survivors receive a benefit if you should die while receiving Disability Benefits?

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

1. your surviving Spouse or Domestic Partner; or
2. your surviving Child(ren), in equal shares, if there is no surviving Spouse or Domestic Partner; or
3. your estate, if there is no surviving Spouse, Domestic Partner, or Child.

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

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

1. your Monthly Rate of Basic Earnings multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.

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

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

The following terms apply to this Benefit:

1. "Spouse" means your wife, or husband, or Domestic Partner who:
 - a) is mentally competent; and
 - b) was not legally separated from you at the time of your death; and
2. "Child" means your son or daughter under age 25 who is dependent on you for financial support.

To be eligible for the benefit payment, any person claiming to be a Domestic Partner may be required to verify, under oath, and to our satisfaction, the facts and circumstances demonstrating the validity and existence of the domestic partnership.

EXCLUSIONS

What Disabilities are not covered?

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

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

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

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

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

TERMINATION

When does your coverage terminate?

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

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

May coverage be continued during a leave of absence?

If you are temporarily granted a leave of absence:

1. and you are a Faculty Member of Professorial Rank, your Employer may continue your insurance for up to 24 months while you are on a paid or unpaid sabbatical or special assignment leave of absence or military leave of absence; or
2. if you are granted any other leave of absence, regardless of your position, your Employer may continue your insurance for up to 6 months, subject to the following:
 - a) the leave authorization is in writing;
 - b) the required premium must be paid;
 - c) your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before said leave commenced; and
 - d) such continuation will cease immediately if one of the following events should occur:
 - i. the leave terminates prior to the agreed upon date;
 - ii. the termination of the Group Insurance Policy;
 - iii. non-payment of premium when due by the Policyholder or you;or
 - iv. the Group Insurance Policy no longer insures your class.

Does your coverage continue if your employment terminates because you are Disabled?

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

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

Must premiums be paid during a Disability?

No premium will be due for you:

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

Do benefits continue if the plan terminates?

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

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

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

May coverage be continued during a family or medical leave?

If you are granted a leave of absence according to the Family and Medical Leave Act of 1993, your Employer may continue your insurance for up to 12 weeks, or longer if required by state law, following the date your coverage would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for you must be paid;
3. your benefit level, or the amount of earnings upon which your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
 - a) the leave terminates prior to the agreed upon date;
 - b) the termination of the Group Insurance Policy;
 - c) non-payment of premium when due by the Policyholder or you; or
 - d) the Group Insurance Policy no longer insures your class.

GENERAL PROVISIONS

What happens if facts are misstated?

If material facts about you were not stated accurately:

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

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

When should we be notified of a claim?

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

Are special forms required to file a claim?

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

What is Proof of Loss?

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

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

All proof submitted must be satisfactory to us.

When must Proof of Loss be given?

Written Proof of Loss must be sent to us within 90 days after the start of the period for which we owe payment. If proof is not given by the time it is due, it will not affect the claim if:

1. it was not possible to give proof within the required time; and
2. Proof of Loss is given as soon as possible; but
3. not later than 1 year after it is due, unless you are not legally competent.

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

When must one apply for Social Security Benefits?

You will be required to apply for Social Security disability benefits when the duration of your Disability meets the minimum duration required to apply for such benefits. If the Social Security Administration denies your eligibility for benefits, you will be required:

1. to follow the process established by the Social Security Administration to reconsider the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

What additional Proof of Loss are we entitled to?

We may have you examined to determine if you are Disabled. Any such examination will be:

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

Who gets the benefit payments?

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

When are payment checks issued?

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

What notification will you receive if your claim is denied?

If a claim for benefits is wholly or partly denied, you will be furnished with written notification of the decision. This written decision will:

1. give the specific reason(s) for the denial;
2. make specific reference to the Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
 - b) 60 days of receipt of claim denial for all other claims; and
2. you may request copies of all documents, records, and other information relevant to your claim; and
3. you may submit written comments, documents, records, and other information relating to your claim.

We will respond to you in writing with our final decision on your claim.

When can legal action be started?

Legal action cannot be taken against us:

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

What happens if benefits are overpaid?

An overpayment occurs when it is determined that the total amount we have paid in benefits is more than the amount that was due to you under the plan.

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

1. retroactive awards of Other Income Benefits;
2. failure to report, or late notification to us of Other Income Benefits or earned income;
3. misstatement; or
4. an error we may make.

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

What are our subrogation rights?

If an Insured Person:

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

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

How do we deal with fraud?

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

Who interprets policy terms and conditions?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.

DEFINITIONS

The terms listed will have these meanings.

Actively at Work

You will be considered to be actively at work with your Employer on a day which is one of your Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a full time basis on that day. You will be deemed to be actively at work on a day which is not one of your Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Active Full-time Employee means a salaried employee, providing you are a legal resident under U.S. law and of the United States, who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours as follows:

Non-Exempt Staff	1,462.5 hours annually
Exempt Staff	1,560 hours annually
Faculty	your status is determined on an individual contractual basis.

Any Occupation, if used in this Booklet-certificate, means an occupation:

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

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

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

Employer means the Policyholder.

Essential Duty means a duty that:

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

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

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

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

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

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

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

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

Monthly Rate of Basic Earnings means your LTD base salary divided by 12. LTD base salary does not include:

1. commissions;
2. bonuses;
3. overtime pay;
4. summer pay;
5. research pay; or
6. any other fringe benefit or extra compensation.

LTD base salary means the employee's budgeted base salary in effect from the Employer, prior to the date Disability begins as defined below:

1. for the period January 1 through June 30, the employee's budgeted base salary as of January 1 or the employee's initial date of eligibility, whichever is the later;
2. for the period of July 1 through December 31, the employee's base salary is the budgeted base salary as of the employee's benefits determination date (July 1 or September 1) or the employee's initial date of eligibility, whichever is the later.

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

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

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
3. plan or arrangement of coverage, whether insured or not, as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization;
4. individual insurance policy where the premium is wholly or partially paid by the Employer;

5. disability benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act, that you, your spouse and children are eligible to receive because of your Disability; or
6. disability benefit from the Veteran's Administration, or any other foreign or domestic governmental agency:
 - a) that begins after you become Disabled; or
 - b) if you were receiving the benefit before becoming Disabled, the amount of any increase in the benefit that is attributed to your Disability.

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

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

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

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

- d) similar plan or act, that you, your spouse and children who are dependent on you for financial support, receive because of your retirement, unless you were receiving them prior to becoming Disabled.

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

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

We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 60 months. We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim. Please see the provision entitled "What happens if benefits are overpaid?".

The amount of any increase in benefits paid under any federal or state law will not be included as Other Income Benefits if such increase:

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

Physician means a person who is:

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

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

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

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

to achieve the maximum medical improvement.

Residual Disability or Residually Disabled means you are prevented by:

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

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

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

1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan, or 457 plan.

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

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

Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled, with respect to Class 1, means that you are prevented by:

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

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

Total Disability or Totally Disabled, with respect to Class 2, means that:

1. during the Elimination Period; and
2. for the next 60 months you are prevented by:
 - a) accidental bodily injury;
 - b) sickness;
 - c) mental illness;
 - d) Substance Abuse; or
 - e) pregnancy,

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

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

Total Disability or Totally Disabled, with respect to Class 3, means that:

1. during the Elimination Period; and
2. for the next 24 month(s), you are prevented by:
 - a) accidental bodily injury;
 - b) sickness;
 - c) mental illness;
 - d) Substance Abuse; or
 - e) pregnancy,

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

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

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

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

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

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

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

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

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

according to the terms of the Policy.

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

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

Richard G. Costello, Secretary

Thomas M. Marra, President

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

SCHEDULE OF INSURANCE

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

The Policyholder: LEHIGH UNIVERSITY

The Policy Number: GL-207718

Policy Effective Date: January 1, 1997

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF JULY 1, 2003.

Anniversary Date: January 1 of each year, beginning in 2008.

Who is eligible for coverage?

All Active Salaried Full-time Faculty and Staff.

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

When will You become eligible? (Eligibility Waiting Period)

You are eligible on the later of either the Policy Effective Date or the date You enter an eligible class.

When will You become eligible for Dependent Coverage?

You will become eligible for Dependent coverage on the later of:

1. the date You become eligible for employee coverage; or
2. the date You acquire Your first Dependent.

What is the Guaranteed Issue Amount?

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

What is Evidence of Good Health?

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

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

When will Evidence of Good Health be required?

Evidence of Good Health is required if You enroll for coverage for Yourself or Your Dependent spouse more than 31 days after the date You are first eligible to do so.

If Evidence of Good Health is not approved in the situation(s) described above, no additional coverage, including the Guaranteed Issue Amount, will become effective. Evidence of Good Health must be provided at Your own expense.

Evidence of Good Health is also required if You elect to increase:

1. Your coverage by more than one option in any 12 month period; or
2. coverage for your spouse.

Evidence of Good Health is not required to increase coverage for Your Dependent child.

Evidence of Good Health is also required if the Amount of Insurance You request for Your Dependents exceeds the Guaranteed Issue Amount for any coverage.

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

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

Are there exceptions to the Evidence of Good Health requirement for late enrolling Dependents?

This Evidence of Good Health requirement will be waived for Your Dependent spouse, if:

1. You do not elect coverage for Your spouse when first eligible to do so, but, within 31 days following the date You acquire Your first child, You elect spouse coverage; or
2. Your spouse was previously covered for life benefits provided by Your spouse's employer group plan; and
 - a) Your spouse has ceased to be covered under the employer's group plan due to Your spouse's loss of employment or cancellation of that group plan;
 - b) Your spouse provides 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.

This Evidence of Good Health requirement will be waived for Dependent children.

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

AMOUNT OF LIFE INSURANCE
Employee Only

What Life benefits are available to You?

Basic Amount of Life Insurance:

An amount equal to 1 times Your base salary as of January 1 of the plan year, rounded to the next higher multiple of \$1,000, if not already such a multiple, subject to a maximum of \$1,500,000.

Supplemental Amount of Life Insurance:

An amount equal to 1, 2, 3 or 4 times Your base salary as of January 1 of the Plan year, rounded to the next higher multiple of \$1,000, if not already such a multiple, subject to a maximum of \$1,500,000.

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

Your Amount of Life Insurance will be reduced by any life benefit:

1. paid to You under an accelerated death benefit in the Prior Plan; and
2. in force for You under any disability extension provision of the Prior Plan.

In no event shall the combined amount of:

- Basic Life Insurance
- Supplemental Life Insurance

exceed \$1,500,000. In the event the combined amount of such coverages would exceed \$1,500,000, any necessary reductions shall come first from the Supplemental Life Insurance and then, if necessary, from the Basic Life Insurance.

If You convert, does it affect the Amount of Life Insurance benefit payable?

The Amount of Life Insurance under the Policy will be reduced by the amount of the individual life insurance issued in accordance with the Conversion Privilege for reasons other than reductions in coverage.

**AMOUNT OF LIFE INSURANCE
Dependent Only****What Life benefits are available to Your Dependents?**

NOTE: The amount of spouse coverage may never exceed 50% of the Amount of Life Insurance in force for the employee.

Supplemental Dependent Spouse:

Option 1 - No Coverage

Option 2 - \$10,000

Option 3 - \$20,000

Option 4:- \$30,000

Supplemental Dependent Children:

15 day(s) of age or older

Option 1 - No Coverage

Option 2 - \$5,000

Option 3 - \$10,000

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

ELIGIBILITY AND ENROLLMENT

Must You contribute toward the cost of coverage?

With respect to Basic Life Insurance coverage, You do not contribute toward the cost.

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

How do You enroll?

If You are not required to contribute toward the cost of coverage, You are not required to request coverage. Enrollment will be automatic. However You will be required to complete a beneficiary election form.

If You must contribute toward the cost of coverage, You are required to enroll for coverage.

To enroll You must:

1. complete and sign a group insurance enrollment form which is satisfactory to Us; and
2. deliver it to the Employer

If You do not enroll within 31 days after becoming eligible, the following limitations will apply to a later enrollment:

1. You must submit Evidence of Good Health unless You are applying to increase Supplemental Life Insurance as described earlier; and
2. You may not enroll until:
 - a) an Annual Enrollment Period; or
 - b) You have a Change in Family Status.

The Annual Enrollment Period for Supplemental Dependent Life Insurance is determined by Your Employer on a yearly basis.

The Annual Enrollment Period for Supplemental Life Insurance is determined by Your Employer on a yearly basis.

What constitutes a Change in Family Status?

A Change in Family Status means:

1. Your marriage, or the birth or adoption of a child, or becoming the legal guardian of a child;
2. the death of or divorce from Your spouse or dissolution of a domestic partnership;
3. the death of or emancipation of a child;
4. spouse's loss of employment which results in a loss of group insurance; or
5. change in classification from Part-time to Full-time or from Full-time to Part-time.

When does coverage start?

If You are not required to contribute toward the cost of coverage, You will become insured on the date You become eligible for coverage.

If You must contribute toward the cost of coverage, Your coverage will start on the latest of the dates determined below:

1. the date You become eligible, if You enroll or have enrolled by then;
2. the date on which You enroll, if You do so within 31 days after the date You are eligible;
3. the date We approve Evidence of Good Health which We may have required; or
4. the first day of the month following the Annual Enrollment Period if You enroll during an Annual Enrollment Period.

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

What is the Deferred Effective Date provision for employees?

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

Are there exceptions to the Deferred Effective Date provision?

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

Instead, You will be considered to be insured and your coverage amount will be the Amount of Life Insurance under the Prior Plan, reduced by any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan.

You will remain insured under this provision until the first to occur of:

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

When does coverage for Your Dependent(s) start?

You are required to enroll for contributory Dependent coverage. To do so You have to complete and sign a group insurance enrollment form acceptable to Us and deliver it to the Employer.

Your spouse will become insured for coverage for which We do not require Evidence of Good Health on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for spouse coverage by then; or
2. the date You enroll for Dependent Coverage, if You do so within 31 days after the date You are eligible.

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

Coverage for which We require Evidence of Good Health will be effective on the later of:

1. the date You become eligible; or
2. the date approved by Us.

Each child will become insured for coverage on the first to occur of:

1. the date You are eligible for Dependent Coverage, if You enroll or have enrolled for child coverage by then; or
2. the date You enroll for coverage for Your child.

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

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

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

What is the Deferred Effective Date provision for Dependents?

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

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

Are there exceptions to the Deferred Effective Date provision for Dependents?

If You were insured with respect to a Dependent under the Prior Plan as of the day before the Policy Effective Date, the Deferred Effective Date provision will not apply to the original effective date of coverage for any Dependent.

Instead, Your Dependent will be considered to be insured and the Amount of Insurance will be the lesser of:

1. The Amount of Insurance in force on the life of the Dependent under the Prior Plan; or
2. the Amount of Insurance shown in the Schedule of Insurance.

When are changes effective?

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

If there is any type of change in Your class, Earnings, the Schedule of Insurance or the Booklet-certificate which:

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

BENEFITS

Life Insurance Benefit

To whom and how are benefits paid?

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

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

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

Unless You have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

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

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

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

If a death benefit payable meets Our guidelines, then the benefit is payable into a checking account. In the case of a Dependent death benefit, You own the checking account. In the case of Your death benefit, Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

Accelerated Death Benefit

What is the benefit?

If You are or Your Dependent is diagnosed as being Terminally Disabled and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and that person is insured for at least \$10,000, then You may request that a portion of that person's Amount of Life Insurance be paid to You prior to death.

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

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

At the time You submit a claim, You will be provided with a Benefit Payment Notice. Such notice will state the amount You have requested to be accelerated and the Amount of Life Insurance remaining following receipt of the benefit.

What does Terminally Disabled mean?

Terminally Disabled means that an individual has a life expectancy of 12 months or less.

What if an individual is no longer Terminally Disabled?

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

What limitations apply to this benefit?

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

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

What if You made an assignment under this plan?

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

**TERMINATION
Employee Coverage**

When does Your coverage terminate?

Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:

1. the date the Policy terminates;
2. the last day of the period for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the date Your Employer terminates Your employment; or
5. the date You are absent from work as an Active Full-time Employee.

CONTINUATION OF COVERAGE AFTER RETIREMENT

Generally your eligibility ends when your employment with the Employer terminates, unless you are a participant in a retirement incentive or severance plan offered by the Employer, for which you qualify, that provides continuation of employer contributory life insurance benefits. This extended eligibility ends when the retirement incentive or severance plan period ends.

If you remain in an Eligible Class, your Life Insurance will remain in force as specified in your retirement incentive or severance agreement. You may elect to receive additional coverage by completing a Benefit Election Form during any Annual Election Period. You may change your coverage during an Annual Election Period or upon the occurrence of a qualifying life event as described above. If you elect additional coverage, you must also complete a Salary Reduction Agreement to permit the additional premiums to be withheld from your retirement incentive or severance payments.

If you retire under any retirement incentive or severance plan, your Employer will pay for the amount of coverage specified in your retirement agreement. If you elect additional coverage, the additional amounts necessary to pay for the premiums will be withheld from your retirement incentive or severance payments pursuant to your Salary Reduction Agreement.

EXCEPTIONS TO TERMINATION

Under what conditions can Your insurance be continued under the continuation provisions?

If You are absent from work as an Active Full-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:

1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

May coverage be continued during a leave of absence?

If You are temporarily granted a paid or unpaid leave of absence:

1. and you are a Faculty Member of Professorial Rank, your Employer may continue your insurance for up to 24 months while you are on a paid or unpaid sabbatical or special assignment leave of absence or military leave of absence; or
2. if you are granted any other leave of absence, regardless of your position, your Employer may continue your insurance for up to 6 months, subject to the following:
 - a) the leave authorization is in writing;
 - b) the required premium must be paid;
 - c) your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before said leave commenced; and
 - d) such continuation will cease immediately if one of the following events should occur:
 - i. the leave terminates prior to the agreed upon date;
 - ii. the termination of the Group Insurance Policy;
 - iii. non-payment of premium when due by the Policyholder or you; or
 - iv. the Group Insurance Policy no longer insures your class.

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

If Your employment status changes from Full-time to Part-time, all of Your coverages (including Dependent Life coverage) may be continued for 3 consecutive month(s) following the date of such change in employment status.

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

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

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

If You are absent from work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time Employee. If You feel that Your condition may continue for an extended period of time, You should request that Your Employer file a waiver of premium claim.

In determining when employment is deemed to terminate for the purposes of termination of any coverage, The Hartford will rely upon your Employer to notify The Hartford, either by telling The Hartford or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if The Hartford and your Employer so agree.

What is Waiver of Premium?

Waiver of premium is a provision which allows for continued employee or Dependent life insurance, without payment of premium, while You are Disabled. You or Your Dependent may not exercise the rights under the Portability provision and qualify for waiver of premium.

To what coverages does the Waiver of Premium apply?

These provisions apply only to Your Basic and Supplemental Life Insurance and Dependent Life Insurance.

What conditions must be satisfied before You qualify for Waiver of Premium?

1. You must be insured and Disabled; and
2. acceptable proof of Your condition must be furnished to Us within one year of Your last day of work as an Active Full-time Employee.

What does Disabled mean?

Disabled means that You have a condition that prevents You from doing any work for which You are or could become qualified by education, training or experience and it is expected that this condition will last for at least nine consecutive months from Your last day of work as an Active Full-time Employee; or You have been diagnosed with a life expectancy of 12 months or less.

When will We waive premium?

We will waive premium after proof that You are Disabled is provided by an attending physician licensed to practice in the United States and We approve the proof. You will be notified by Us of the date We will begin to waive premium.

What if You or Your Dependent die before You qualify for Waiver of Premium?

If:

1. You or Your Dependent should die within one year of Your last day of work as an Active Full-time Employee but prior to qualifying for waiver of premium; and
2. You were Disabled,

We will pay the Amount of Life Insurance which is in force for You or Your Dependent. Your Dependent Life coverage will terminate on the date You die. They may be eligible for conversion as of that date.

Can We have You examined for proof that You continue to be Disabled?

During the first two years following the date You qualify as Disabled, We may have You examined at reasonable intervals. Thereafter, We will only require an annual examination to confirm that You continue to be Disabled. If You fail to submit any required proof or refuse to be examined as required by Us, then Your coverage will terminate.

What if You are no longer Disabled?

If, for any reason, You are no longer Disabled, Your premium will no longer be waived. On that date, You may or may not return to work.

If You return to work in an Eligible Class, then all of Your coverages will be reinstated subject to the terms of the Policy in effect on the reinstatement date.

If You do not return to work within an Eligible Class, and You are not eligible for any other group life insurance from Lehigh University, then You are entitled to the Conversion Privilege. You may convert the Amount of Life Insurance that is in force for You and Your Dependent on the date it is determined that You are no longer Disabled.

On the date waiver of premium terminates, if You do not return to work, You will be entitled to convert Your coverage. You may convert no more than Your Amount of Life Insurance that is in force on the date waiver of premium terminates. On the date the waiver of premium terminates for Dependent Life coverage, Your Dependents may be eligible to convert.

What if the Policy terminates before You qualify for waiver of premium?

If the Policy terminates before You qualify for waiver of premium, You may be eligible to convert. Additionally, You may later be approved for waiver of premium.

What if the Policy terminates after You qualify for waiver of premium?

Termination of the Policy will not affect Your coverage under the terms of this provision.

DEPENDENT COVERAGE

When does Dependent Coverage terminate?

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

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

EXCEPTIONS TO TERMINATION

Under what conditions can Dependent child insurance be continued?

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

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

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

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

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

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

PORTABILITY

When can a person elect Portability?

You may elect portability if:

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

A Dependent may elect portability if:

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

In order for a Dependent child to choose Portability, You and/or Your spouse must elect Portability as well.

What does Retirement mean?

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

Will the Waiver of Premium provision be available if You elect to continue coverage under this Portability provision?

No.

Will Conversion be available if a person elects to continue coverage under this Portability provision?

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

How is Portability elected?

A person must, within 31 days of the date group coverage terminates:

1. make written application to Us; and
2. pay the required premium.

If this is done, We will issue a certificate of insurance under a group portability policy. Such coverage will be:

1. issued without evidence of good health;
2. on one of the forms then being issued by Us for portability purposes; and
3. effective on the day following the date insurance terminates.

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

What limitations apply to this benefit?

A person may elect to continue 50%, 75% or 100% of his amount of life insurance being terminated. Such amount will be rounded to the next higher \$1,000, if not already an even multiple thereof. No employee's amount of life insurance continued may exceed \$250,000. No spouse amount of life insurance continued may exceed \$30,000. No child's amount of life insurance continued may exceed \$10,000.

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

How much does Portability cost?

See Your Employer for the cost.

CONVERSION PRIVILEGE

When can an individual convert?

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

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

What is the conversion policy?

The conversion policy will:

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

How much can be converted?

If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:

1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage through Lehigh University for which the individual becomes covered within 31 days of termination of group coverage; or
2. \$2,000.

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

How does an individual convert coverage?

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

What if death occurs during the conversion election period?

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

GENERAL PROVISIONS

When can this plan be contested?

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

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

Who interprets policy terms and conditions?

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

Are there any rights of assignment?

You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:

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

No absolute assignment of rights and interest shall be binding on Us until and unless:

1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:

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

How do You designate or change Your beneficiary?

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

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

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

What recourse do You have if Your claim is denied?

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
 - b) 60 days of receipt of claim denial for all other claims; and
2. you may request copies of all documents, records, and other information relevant to your claim; and
3. you may submit written comments, documents, records, and other information relating to your claim.

We will respond to you in writing with our final decision on your claim.

DEFINITIONS

Active Full-time Employee — means a salaried employee, providing you are a legal resident under U.S. law and of the United States, who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours as follows:

Non-Exempt Staff	1,462.5 hours annually
Exempt Staff	1,560 hours annually
Faculty	your status is determined on an individual contractual basis.

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

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

Dependent

- (1) Your spouse; and
- (2) Your unmarried child who:
 - (a) is at least 15 days old but not yet 19 years old; or
 - (b) is 19, but has not yet attained age 23, is primarily dependent upon You for financial support and attends an accredited school (other than a correspondence school) on a regular and full-time student basis as his principal activity; or
 - (c) is 19 years old or older and is disabled and primarily dependent upon You for financial support. Such child must have become disabled before attaining age 19.

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

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

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

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

The term "child", shall also include You:

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

You may not elect coverage for Your Dependent if Your Dependent is covered as an employee under the Policy. Any person who is in Full-time military, naval or air force service cannot be a Dependent. No person can be insured as a Dependent of more than one employee under the Policy.

Earnings/Base Salary - Your Base Salary is your budgeted salary as of January 1 of each plan year. This does not include overtime, bonuses, summer support, payments related to summer school programs or other forms of additional compensation.

Employer – The Policyholder named in the Schedule of Insurance.

He/His – He or she. His or her.

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

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

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

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 material combined with the information in the booklet certificate forms your summary plan description.

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

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

1. Plan Name

Group Long Term Disability, Life and Supplemental Life Plan for employees of LEHIGH UNIVERSITY.

2. Plan Number

LIFE - 514

LTD - 507

3. Employer/Plan Sponsor

LEHIGH UNIVERSITY
Treasurer's Office
Alumni Memorial Building
27 Memorial Drive West
Bethlehem, PA 18015

4. Employer Identification Number

24-0795445

5. Type of Plan

Welfare Benefit Plan providing Group Long Term Disability, Life and Supplemental Life Benefits.

6. Plan Administrator

LEHIGH UNIVERSITY
Attn: Associate Vice President for Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015

7. Agent for Service of Legal Process

For the Plan

LEHIGH UNIVERSITY
Director of Benefits and Compensation
428 Brodhead Avenue
Bethlehem, PA 18015

For the Policy:

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

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

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

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

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

11. **Labor Organizations**

None

12. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

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

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

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

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

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

Appealing Denials of Claims for Benefits

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

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

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

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

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

The Plan Described in this Booklet

is Insured by the

Hartford Life and Accident Insurance Company

Hartford, Connecticut

Member of The Hartford Insurance Group