YOUR BENEFIT PLAN

THE AEROSPACE CORPORATION

Short Term Disability

Maryland

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

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at https://www.thehartford.com/. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202
2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you

California:

1. **NOTICE:** READ YOUR CERTIFICATE CAREFULLY
   You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We

will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.

2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

   Eligibility Determination: *How will We determine Your eligibility for benefits?*
   We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility or Your beneficiaries for benefits for any claim You or Your beneficiaries make on The Policy. We will:
   1) obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
   2) as a part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
   3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
   4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

   In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal**. If You do not appeal the decision to Us, then the decision will be Our final decision.
3. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833
   Web Address: www.insurance.ca.gov

Colorado:

1. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
2. The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

   Complications of Pregnancy means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:
   1) acute nephritis or nephrosis;
   2) cardiac decompensation;
   3) missed abortion; and
   4) similar medical and surgical conditions of comparable severity.

   Complications of Pregnancy will also include:
   1) pre-eclampsia;
   2) placenta previa;
   3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
   4) termination of ectopic pregnancy;

5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
6) non-elective Cesarean section; and
7) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:
1) elective Cesarean section;
2) false labor, occasional spotting, or morning sickness;
3) hyperemesis gravidarum; or
4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.

3. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.
4. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Florida:

1. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Georgia:

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

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov
2. **Notice to Buyer: This is a disability income protection policy.**
3. The **Benefits Commence** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot exceed:
   1) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;
   2) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or
   3) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.
4. The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months. If the plan design includes both short tern and long term disability benefits, the combined short term disability and long term disability **Maximum Duration of Benefits** cannot be less than 6 months.

Illinois:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **For Your Questions and Complaints:**
   Illinois Department of Insurance
   Consumer Services Station
   Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of

insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq*. Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at https://idoi.illinois.gov.

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Kansas:

1. The following requirement applies to you:

   Policy Interpretation: *Who interprets Policy terms and conditions?*
   Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are a fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1. The following requirement applies to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*
   If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

   The reinstated coverage will:
   1) be the same coverage amounts in force on the date coverage ended;
   2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
   3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The benefits under this policy are subject to reduction due to other sources of income.

This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under this policy.

Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

What comprises other sources of income under this policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully.** A full description of the plans and types of plans considered to be other sources of income under this policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.

2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.
3. The following requirement applies to you:

   Reinstatement: *Can my coverage be reinstated after it ends?*
   We will reinstate The Policy upon receipt of all current and late premiums if:
   1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
   2) all current and late premium payments are received within 15 days of Our request.

   We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

Massachusetts:

1. The following continuation requirement applies to you:

   In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

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

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Missouri:

1. The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

Montana:

1. **NOTICE:** Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.
2. Pregnancy will be covered, the same as any other Sickness, anything in The Policy to the contrary notwithstanding.
3. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Exclusions and Limitations** section, is 3 consecutive months. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until You have been treatment free or continuously insured for 9 consecutive months, or less respectively, if shown in the Certificate.
4. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
5. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
6. **Notice: READ YOUR CERTIFICATE CAREFULLY -** You have a 30 day right to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days from the later of Your original Certificate Effective Date or the date The Policy was received by the Policyholder. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
7. **Notice:** The Policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

New York:

1. The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that represents or compensates for Your loss of earnings.
2. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

   The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
   1) you are both legally and mentally competent to consent to contract in the state in which you reside;
   2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
   3) you have been living together on a continuous basis prior to the date of the application;
   4) neither of you have been registered as a member of another domestic partnership within the last six months; and

5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

1) a joint bank account;
2) a joint credit card or charge card;
3) joint obligation on a loan;
4) status as an authorized signatory on the partner's bank account, credit card or charge card;
5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
6) listing of both partners as tenants on the lease of the shared residence;
7) shared rental payments of residence (need not be shared 50/50)
8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
10) shared household budget for purposes of receiving government benefits;
11) status of one as representative payee for the other's government benefits;
12) joint responsibility for child care (e.g., school documents, guardianship);
13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
14) execution of wills naming each other as executor and/or beneficiary;
15) designation as beneficiary under the other's life insurance policy;
16) designation as beneficiary under the other's retirement benefits account;
17) mutual grant of durable power of attorney;
18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
19) affidavit by creditor or other individual able to testify to partners' financial interdependence;
20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1) The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2) The **Other Income Benefits** definition will not include a mandatory "no-fault" automobile insurance plan.
3) You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4) The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5) Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
6) The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within 180 days following the completion of the **Elimination Period**.
7) The **Claims to be Paid** provision is amended to state that We may pay up to $3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
8) **Notice of Claim** may also be given to Our representative, if applicable.
9) **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE

PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

IMPORTANT TERMINATION INFORMATION

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

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

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

READ YOUR CERTIFICATE CAREFULLY.

Oregon:

1. The following Jury Duty continuation applies for Employers with 10 or more employees:

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
   1) the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
   2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

   This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.
2. The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable

2. **NOTICE:**

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford
Email: gbdcustomerservice@thehartford.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford
Correo electrónico: gbdcustomerservice@thehartford.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

Vermont:

1. The following requirement applies:

   Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

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

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

   CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

   Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as “ERISA”, controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Virginia:

1. **For Your Questions and Complaints:**
   State Corporation Commissions
   Life and Health Division
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   1(804) 371-9691 (inside Virginia)
   1(877) 310-6560 (outside Virginia)

Washington:

1. The following continuation applies to you:

   General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

Wisconsin:

1. **For Your Questions and Complaints:**
   To request a Complaint Form:
   Office of the Commissioner of Insurance
   Complaints Department
   P.O. Box 7873
   Madison, WI 53707-7873
   1(800) 236-8517 (within Wisconsin)
   1(608) 266-0103 (outside of Wisconsin)

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

Read Your Certificate of Insurance Carefully. This outline of coverage provides a very brief description of some important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Certificate of Insurance itself sets forth, in detail, the rights and obligations of both you and Hartford Life and Accident Insurance Company. It is, therefore, important that you read Your Certificate of Insurance carefully!

1) Disability Income Protection Coverage: This category of coverage is designed to provide You income protection benefits for disabilities resulting from an injury or sickness, subject to any limitations set forth in The Policy. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

2) Benefits: If You meet the definition of Disability or Disabled found in the Definitions section of Your Certificate of Insurance, You may be eligible to receive benefits. You may meet the definition if Disability or Disabled if You are unable to perform one or more of the Essential Duties of Your Occupation. You may need to satisfy an Benefits Commence Period before You are eligible to receive benefits. The Benefits Commence Period may be found in the Schedule of Insurance in Your Certificate of Insurance. The benefits provided by Your coverage, including payment periods, are indicated in the Schedule of Insurance in Your Certificate of Insurance. Each benefit contained in the Schedule of Insurance is described in detail in the Benefits section of Your Certificate of Insurance.

3) Exceptions, Reductions, and Limitations: There may be exceptions, reductions, and limitations to Your benefits under The Policy. This may include, but is not limited to:
    a) requiring You to submit Evidence of Insurability to determine eligibility for coverage and eligibility for increases in coverage;
    b) terminating Your coverage and/or the entire insurance contract for non-payment of premium;
    c) limiting the amount and duration of Your benefits or restricting coverage:
        i) for certain conditions; or
        ii) because You were not under the Regular Care of a Physician;
    d) not covering Your Disability or Loss because of the circumstances which contributed to or caused the Disability or Loss;
    e) reducing Your benefit based on their age;
    f) ending Your coverage on the date You attain the policy age limit; and
    g) limiting or restricting benefits for Pre-existing Conditions.

4) Continuation of Coverage: Your coverage may be continued or terminated under certain circumstances. These provisions are fully described in the Period of Coverage section of Your Certificate of Insurance. You may be subject to eligibility requirements. These provisions are fully described in the Eligibility and Enrollment section of Your Certificate of Insurance.

5) Premiums/Contributions: We have the right to change the rate of premiums and the factors, other than claims experiences, which affect changes in the rate. Premiums are established or may be changed based on age, class, smoker or non-smoker status. We will give the Policyholder notice of any changes. You may or may not need to contribute toward the cost of Your coverage. The Schedule of Insurance section of Your Certificate of Insurance will provide information on whether or not You need to contribute toward the cost of Your coverage.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company, herein called The Company)

CERTIFICATE OF INSURANCE

Policyholder: THE AEROSPACE CORPORATION
Policy Number: GRH-402802
Policy Effective Date: January 1, 2015
Policy Anniversary Date: January 1, 2023

Employee Name: _____
Employee Number: _____

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

Signed for The Company

Kevin Barnett, *Secretary* **Michael J. Fish, *Head of Group Benefits***

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

TABLE OF CONTENTS

SCHEDULE OF INSURANCE....18
Cost of Coverage....18
Eligibility Waiting Period for Coverage....18
Weekly Benefit....18
ELIGIBILITY AND ENROLLMENT....18
Eligible Persons....18
Eligibility for Coverage....19
Enrollment....19
Evidence of Insurability....19
PERIOD OF COVERAGE....19
Effective Date....19
Deferred Effective Date....20
Changes in Coverage....20
Termination....20
Continuation Provisions....21
BENEFITS....21
Disability Benefit....21
Termination of Payment....22
Disabled and Working Benefit....22
EXCLUSIONS AND LIMITATIONS....23
GENERAL PROVISIONS....23
DEFINITIONS....26

SCHEDULE OF INSURANCE

The Policy of short term Disability insurance provides You with short term income protection if You become Disabled from a covered Injury, Sickness, or pregnancy.

The benefits described herein are those in effect as of March 1, 2025.

Cost of Coverage:
You must contribute toward the cost of coverage.

Disclosure of Fees:
We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Eligible Class(es) For Coverage:
All Full-time and Part-time Active Employees who are non-California employees who are citizens or legal resident of the United States, its territories and protectorates; excluding employees who would be eligible for the 90% CASDI weekly benefit based on their SAWW as stated in California Unemployment Insurance Code 2655(f)(1)(B), temporary, leased or seasonal employees.

Full-time Employment: at least 40 hours weekly
Part-time Employment: at least 20 hours weekly on average, in a 12 month period

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:
None

Benefits Commence:
1) for Disability caused by Injury: on the 8th day of Total Disability or Disabled and Working;
2) for Disability caused by Sickness: on the 8th day of Total Disability or Disabled and Working.

Weekly Benefit:
The lesser of:
1) 70% of Your Pre-disability Earnings; or
2) $1,681;

reduced by Other Income Benefits.

Minimum Weekly Benefit:
$50

Maximum Duration of Benefits Payable:
1) 52 week(s) if caused by Injury; or
2) 52 week(s) if caused by Sickness.

Additional Benefits:

Disabled and Working Benefit
see benefit

ELIGIBILITY AND ENROLLMENT

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

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

Enrollment: *How do I enroll for coverage?*
To enroll for coverage You must:
1) complete and sign a group insurance enrollment form; and
2) deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll:
1) You must give Us Evidence of Insurability that is complete and does not disqualify You from coverage; and
2) You may only enroll:
   a) during an Annual Enrollment Period designated by the Policyholder; or
   b) within 31 days of the date You have a Change in Family Status.

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

Evidence of Insurability: *What is Evidence of Insurability and what happens if Evidence of Insurability is incomplete or disqualifies You from coverage?*
Evidence of Insurability may include:
1) a completed and signed application;
2) a medical examination, if requested;
3) attending Physicians' statements; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Our expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is incomplete or disqualifies You from coverage:
1) Your Weekly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married or You execute a domestic partner affidavit or have registered as domestic partners with a government agency or office where such registration is available;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your or Your domestic partner's child is born or You or Your domestic partner adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
Your coverage will start on the earliest of:
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 Your Evidence of Insurability is approved, for benefit amounts requiring Evidence of Insurability; or

4) on the January 1st following the Annual Enrollment Period if You enroll, for benefit amounts not requiring Evidence of Insurability, during an Annual Enrollment Period.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:
1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

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

Changes in Coverage: *Can I change my benefit options?*
You may change Your benefit option only:
1) during an Annual Enrollment Period; or
2) within 31 days of a Change in Family Status.

At such time You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

When will a requested change in benefit option take effect?
If You enroll for a change in benefit option during an Annual Enrollment Period, the change will take effect on the later of:
1) the January 1st following the Annual Enrollment Period; or
2) the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the later of:
1) the date You enroll for the change; or
2) the date We approve Your Evidence of Insurability if You are required to submit Evidence of Insurability.

Any such increase in coverage is subject to the Deferred Effective Date.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:
1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?
Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the Deferred Effective Date provision.

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*
If You were:
1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the end of the month following the date The Policy terminates;
2) the end of the month following the date The Policy no longer insures Your class;
3) the end of the month following the date premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the end of the month following the date Your Employer terminates Your employment; or

6) the end of the month following the date You cease to be a Full-time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in The Policy;
2) is subject to payment of premium by the Employer; and
3) terminates if:
   a) The Policy terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Layoff: If You are temporarily laid off by the Employer due to lack of work, Your coverage may be continued for 15 day(s) after the month in which the layoff commenced. If the layoff becomes permanent, this continuation will cease immediately.

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

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive short term Disability Benefits;

provided premiums for Your coverage continued to be paid.

After short term Disability Benefit payments have ceased, Your insurance will be reinstated, provided:

1) You return to work for one full day as a Full-time Active Employee in an eligible class;
2) The Policy remains in force; and
3) the premiums for You were paid during Your Disability, and continue to be paid.

Extension of Benefits for Disability: *Do benefits continue if The Policy terminates?*
If You are entitled to benefits while Disabled and The 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 of The Policy for any reason will have no effect on Our liability under this provision.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Policy?*
If, while covered under this Benefit, You:

1) become Disabled;
2) remain Disabled; and
3) submit Proof of Loss to Us;

We will pay the Weekly Benefit.

If You are Disabled and return to work in some capacity, the amount of any Weekly Benefit payable for the first 52 weeks while You are working will be reduced by:

1) the total amount of all Other Income Benefits; and
2) Current Weekly Earnings received from the Employer that exceed 100% of Your Pre-disability Earnings when added to the Weekly Benefit payable.

Minimum Weekly Benefit: *Is there a Minimum Weekly Benefit?*
Your Weekly Benefit will not be less than the Minimum Weekly Benefit shown in the Schedule of Insurance.

Loss of License: If You are in an occupation that requires You to maintain a license, Your failure to pass a physical examination required to maintain that license does not alone mean that You are Disabled from Your Occupation.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*
If a Weekly Benefit is payable for less than a week, We will pay 1/7 of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*
When Your return to work as an Active Employee is followed by a Disability, and such Disability is:

1) due to the same cause; or
2) due to a related cause; and
3) within 60 consecutive calendar days 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 Policy remains in force.

If You return to work as an Active Employee for 60 consecutive calendar days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*
If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:

1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions will apply to the new cause of Disability.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:

1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment by Your treating Physician that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits;
8) the date Your Current Weekly Earnings are equal to or greater than 80% of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation for a period exceeding 12 months; or
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*
If, while covered under this benefit, You are Disabled and Working, as defined, and Disability Benefit payments for Total Disability under The Policy have begun, Your Weekly Benefit will be reduced by Your Current Weekly Earnings only to the extent that such earnings when added to the Weekly Benefit payable exceed 100% of Your weekly Pre-disability Earnings.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*

If a Weekly Benefit is payable for less than a week, We will pay 1/7 of the Weekly Benefit for each day You were Disabled.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and We will not pay a benefit for, any Disability:

1) unless, after satisfying the Benefit Commencement period, You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) 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 Your Employer; and
2) was terminated before the Effective Date of The Policy;

no benefits will be payable for the Disability under The Policy.

GENERAL PROVISIONS

Notice of Claim: *When should I notify The Company of a claim?*
Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by The Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at Sacramento, CA, with information sufficient to identify the insured Active Employee, shall be deemed notice to Us.

Claim Forms: *Are special forms required to file a claim?*
We, upon receipt of a notice of claim, will furnish to You such forms as are usually furnished by Us for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice You shall be deemed to have complied with the requirements of The Policy as to proof of loss upon submitting, within the time fixed in The Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss: *What is Proof of Loss?*
Written Proof of Loss must be furnished to Us, in case of claim for loss for which The Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claim: *When are benefit payments issued?*
Indemnities payable under The Policy for any loss other than loss for which The Policy provides periodic payments will be paid as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which The Policy provides periodic payment will be paid monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims: *To whom will my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any indemnity of The Policy shall be payable to the estate of the insured employee, or to an insured employee or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

Physical Examinations and Autopsy: *Will I be examined during the course of my claim?*

We at Our own expense shall have the right and opportunity to examine the person of the insured when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Claim Denial: *What notification will I receive if my 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 notification 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 perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*
On any claim, You or Your representative may appeal to Us for a full and fair review. To do so, You:

1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) 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 the claim.

Social Security and Other Income Benefits: *When must I apply for Social Security and Other Income Benefits?*
You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. You will be required to follow the process established by the Social Security Administration, provided We believe such action can reasonably be expected to result in an award. Social Security Assistance, through a vendor, is available to help You with the application process.

If You are eligible for benefits under The Canadian Pension Plan, The Quebec Pension Plan, Railroad Retirement Act, or other similar government plan You will be required to apply for such benefits if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits You are eligible to receive with reasonable diligence, provided We believe such action can reasonably be expected to result in an award.

If Your Disability was caused by a work injury, You will be required to apply for Workers' Compensation benefits with Your employer if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence, provided We believe such action can reasonably be expected to result in an award.

If You are eligible for benefits from California State Disability Insurance or disability insurance from another state, You will be required to apply for California State Disability Insurance or disability insurance from another state if such action can reasonably be expected to result in such an award. You will be required to pursue those benefits with reasonable diligence, provided We believe such action can reasonably be expected to result in an award.

Benefit Estimates: *When does the Company estimate Social Security and Other Income Benefits?*
We will use any reasonable means to estimate the amount of Other Income Benefits payable under the Social Security Administration's Disability Income Program, the Canadian Pension Plan, The Quebec Pension Plan or any similar plan or act if We reasonably believe You and Your spouse and children are entitled to receive them but You and Your spouse and children have not applied; or failed to pursue them with reasonable diligence; or You have failed to provide Us with proof that You and Your spouse and children have applied for and reasonably pursued these benefits. We will deduct the estimated amount of this benefit from Your Monthly Benefit payable under this plan even if You and Your spouse and children are not receiving these benefits.

We will use any reasonable means to estimate the amount of temporary disability benefits payable to You under a workers compensation law or any other occupational disease law or similar act; or the amount of benefits payable to You under any statutory benefit law, plan or act if We reasonably believe You are entitled to receive them but You have not applied; or failed to pursue them with reasonable diligence; or failed to provide Us with proof that You have applied for and reasonably pursued these benefits. We will deduct the estimated amount of these benefits from Your Monthly Benefit payable under this plan even if You are not receiving these benefits.

Overpayment: *When does an overpayment occur?*
An overpayment occurs:

1) if the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2) when payment is made by Us that should have been made under another group policy.

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

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

Overpayment Recovery: *How does The Company exercise the right to recover overpayments?*
We have the right to recover from You any amount that is an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days or contact Us to establish a reasonable recovery plan.

If reimbursement is not made in a timely manner, We have the right to:

1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

Subrogation: *What are The Company's subrogation rights?*
If You:

1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) initiate legal action for the recovery of such benefits from the Third Party;

then We will be subrogated to any rights You may have against the Third Party.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Reimbursement: *What are The Company's Reimbursement Rights?*
We have the right to request to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

a) a legal judgment;
b) an arbitration award; or
c) a settlement or otherwise;

You must reimburse Us for the lesser of:

a) the amount of payment made or required to be made by Us; or
b) the amount recovered from the Third Party, attributable to loss of income, less any reasonable legal fees associated with the recovery.

Third Party as used in this provision, means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions: *When can legal action be taken against Us?*
No action at law or in equity shall be brought to recover on The Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of The Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

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

The falsity of any statement in the application shall not prevent the right to recovery under The Policy unless such false statement was made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by Us.

Time Limit on Certain Defenses: *What happens if facts are misstated?*
After this Policy has been in force for a period of two years, no statements of the Employer contained in the application, and no statement relating to insurability made by any Active Employee eligible for coverage under The Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

Other Misstatements: *What happens if other facts are misstated?*
If other 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.

Eligibility Determination: *How will We determine Your eligibility for benefits?*
We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility or Your beneficiaries for benefits for any claim You or Your beneficiaries make on The Policy. We will:
1) obtain with Your cooperation and authorization if required by law, only such information that is necessary to evaluate Your claim and decide whether to accept or deny Your claim for benefits. We may obtain this information from Your Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your option and at Your expense, You may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your choice. You should provide Us with all information that You want Us to consider regarding Your claim;
2) as a part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
3) if We approve Your claim, We will review Our decision to approve Your claim for benefits as often as is reasonably necessary to determine Your continued eligibility for benefits;
4) if We deny Your claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial.**

In the event We deny Your claim for benefits, in whole or in part, You can appeal the decision to Us. If You choose to appeal Our decision, the process You must follow is set forth in The Policy provision entitled **Claim Appeal.** If You do not appeal the decision to Us, then the decision will be Our final decision.

DEFINITIONS

Actively at Work means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:
1) in the usual way; and
2) for Your usual number of hours.

Provided You were not Disabled, We will consider You Actively at Work on a day that is not a scheduled work day if You were:

1) Actively at Work on the preceding scheduled work day; or
2) on a normal vacation day.

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

Current Weekly Earnings means weekly earnings You receive from:

1) Your Employer; and
2) another employer with whom You became employed after Your Disability began;

while You are Disabled and eligible for the Disabled and Working Benefit.

Disabled and Working means a partial disability in which You are not Totally Disabled, and while actually working in an occupation, as a result of Sickness or Injury, You are unable to engage with reasonable continuity in that or any other occupation in which You could reasonably be expected to perform satisfactorily in light of Your age, education, training, experience, station in life and physical and mental capacity.

Disability or Disabled means Total Disability or Disabled and Working Disability.

Employer means the Policyholder.

Essential Duties means the substantial and material acts that are normally required for the performance of Your Usual Occupation, which cannot reasonably be omitted or modified.

Injury means physical harm or damage to the body resulting from the proximate cause of the loss; which occurs within 30 days while You are covered under The Policy. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the loss.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Disability due to the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders are considered a Sickness and not a Mental Illness:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
5) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Other Income Benefits means the amount of any benefit for loss of income, provided to You, as a result of the Disability for which You are claiming benefits under The Policy. This includes any such benefits that are paid to You, or to a third party subject to a court ordered garnishment, guardianship or conservatorship, on Your behalf, pursuant to any:

1) temporary 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) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) 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/or children, are eligible to receive because of Your Disability; or
4) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You, or to a third party subject to a court ordered garnishment, guardianship or conservatorship, on Your behalf, pursuant to any:

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

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.).

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

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

You will not be required to claim any retirement benefits which You may only get on a reduced basis.

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

We may require:

1) Your signed statement identifying all Other Income Benefits; and
2) proof that You and Your spouse and/or children have duly applied for all Other Income Benefits We reasonably believe You and Your spouse and/or children are entitled to or eligible to receive as a result of the Disability for which You are claiming benefits under this plan.

Physician means a person who is:

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

Pre-disability Earnings means Your regular weekly rate of pay not counting bonuses, commissions and tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the last day You were Actively at Work before You became Disabled.

However, if You were an hourly paid Active Employee before You became Disabled, Pre-disability Earnings means the product of:

1) the average number of hours You worked per week, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
2) Your hourly wage in effect immediately prior to the last day You were Actively at Work before You became Disabled.

Prior Policy means the short term disability insurance carried by the Employer on the day before the Policy Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are 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 necessary to improve the disabling condition or until maximum recovery is achieved.

Related means Your spouse, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Sickness means any condition, illness, disease or disorder of the body or mind, but not an Injury.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances, other than as prescribed and directed by a physician, 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.

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

Total Disability or Totally Disabled means as a result of Injury or Sickness You are unable to perform with reasonable continuity the Essential Duties necessary to pursue Your Usual Occupation in the usual or customary way.

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

Weekly Benefit means a weekly sum payable to You while You are Disabled, subject to the terms of The Policy.

Your Occupation or Your Usual Occupation means any employment, business, trade or profession and the Essential Duties of the occupation You were regularly performing for the Employer when the Disability began. Your Occupation or Your Usual Occupation is not necessarily limited to the specific job You performed for the Employer.

You or Your means the person to whom this 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 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 and Booklet are incorporated into, and form 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, to the extent permitted by applicable state law.

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

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1. **Plan Name**

   Group Short Term Disability Plan for employees of THE AEROSPACE CORPORATION.

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2. **Plan Number**

   WD - 501

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3. **Employer/Plan Sponsor**

   THE AEROSPACE CORPORATION
   DIRECTOR
   Employee Benefits Health & Welfare
   Post Office Box 92957, M1/444
   Los Angeles, CA 90009-2597

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4. **Employer Identification Number**

   95-2102389

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5. **Type of Plan**

   WELFARE BENEFIT PLAN.

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6. **Plan Administrator**

   THE AEROSPACE CORPORATION
   DIRECTOR
   Employee Benefits Health & Welfare
   Post Office Box 92957, M1/444
   Los Angeles, CA 90009-2597

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

For the Plan

THE AEROSPACE CORPORATION
Post Office Box 92957, M1/040
Los Angeles, CA 90009-2597

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

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

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8. **Sources of Contributions (Short Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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

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

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11. **Labor Organizations**

OFFICE OF THE GENERAL COUNSEL
THE AEROSPACE CORPORATION
2310 East El Segundo Blvd.
El Segundo, CA 90245-4691

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12. **Names and Addresses of Trustees**

THE AEROSPACE CORPORATION
Post Office Box 92957, M1/040
Los Angeles, CA 90009-2597

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13. **Plan Amendment Procedure**

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

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

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

4. Assistance with Your Questions

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

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

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 Insurance Company, 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 the Insurance Company receives 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) the specific reason or 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 Insurance Company's 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 the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) 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 your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

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, with the exception of an action under the deemed exhausted process described above. 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.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

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 the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

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, the Insurance Company 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) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a

disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

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