Your Group Plan

University of Connecticut

Long Term Disability

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(Defines the Terms Shown in Bold Type in the Text of This Document.)

Note: The codes appearing on the left side of certain blocks of text are required by the Department of Insurance.

Your Group Coverage Plan

This Plan is underwritten by the Aetna Life Insurance Company, of Hartford, Connecticut (called Aetna). The benefits and main points of the group contract for persons covered under this Plan are set forth in this Booklet. They are effective only while you are covered under the group contract.

If you become covered, this Booklet will become your Certificate of Coverage. It replaces and supersedes all Certificates issued to you by Aetna under the group contract.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Group Policy: GP-473072
Cert. Base: 3
Issue Date: August 31, 2007
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This Certificate may be an electronic version of the Certificate on file with your Employer and Aetna Life Insurance Company. In case of any discrepancy between an electronic version and the printed copy which is part of the group insurance contract issued by Aetna Life Insurance Company, or in case of any legal action, the terms set forth in such group insurance contract will prevail. To obtain a printed copy of this Certificate, please contact your Employer.

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Long Term Disability Coverage

This Plan will pay a Monthly Benefit for a period of disability caused by a disease or **injury**. There is an elimination period. (This is the length of time during a period of disability that must pass before benefits start.)

Test of Disability

From the date that you first become disabled and until Monthly Benefits are payable for 36 months, you will be deemed to be disabled on any day if:

- you are not able to perform the **material duties** of your **own occupation** solely because of: disease or **injury**; and
- your work earnings are 80% or less of your **adjusted predisability earnings**.

After the first 36 months that any Monthly Benefit is payable during a period of disability, you will be deemed to be disabled on any day if you are not able to work at any **reasonable occupation** solely because of:

- disease; or
- **injury**.

If your **own occupation** requires a professional or occupational license or certification of any kind, you will not be deemed to be disabled solely because of the loss of that license or certification.

11201, 11519

Monthly Benefit

The Scheduled Monthly LTD Benefit, the Maximum Monthly Benefit, and the Minimum Monthly Benefit are shown on the Summary of Coverage.

The monthly benefit is an amount based on your monthly predisability earnings. Other income benefits, as defined later, are taken into account.

- If no other income benefits are payable for a given month:

  The monthly benefit payable under this Plan for that month will be the lesser of:

  the Scheduled Monthly LTD Benefit; and

  the Maximum Monthly Benefit.

- If other income benefits are payable for a given month:

  The monthly benefit payable under this Plan for that month will be the lesser of:

  the Scheduled Monthly LTD Benefit; and

  the Maximum Monthly Benefit;

  minus all other income benefits, but not less than the Minimum Monthly Benefit.

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When Benefits Are Payable

Monthly benefits will be payable if a period of disability:

- starts while you are covered; and
- continues during and past the elimination period.

These benefits are payable after the elimination period ends for as long as the period of disability continues.

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A Period of Disability

A period of disability starts on the first day you are disabled as a direct result of a significant change in your physical or mental condition occurring while you are insured under this Plan. You must be under the regular care of a **physician**. (You will not be deemed to be under the regular care of a **physician** more than 31 days before the date he or she has seen and treated you in person for the disease or **injury** that caused the disability.)

Your period of disability ends on the first to occur of:

- The date Aetna finds you are no longer disabled or the date you fail to furnish proof that you are disabled.
- The date Aetna finds that you have withheld information which indicates you are performing, or are capable of performing, the duties of a **reasonable occupation**.
- The date you refuse to be examined by, or cooperate with, an independent **physician** or a licensed or certified health care practitioner, as requested.
- The date you cease to be under the regular care of a **physician**.
- The date an independent medical exam report or functional capacity evaluation fails to confirm your disability.
- The date you reach the end of your Maximum Benefit Duration.
- The date you are not undergoing **effective treatment for alcoholism or drug abuse**, if your disability is caused to any extent by alcoholism or drug abuse.
- The date you refuse to cooperate with or accept:

  changes made to a work site or job process to suit your identified medical limitations; or

  adaptive equipment or devices designed to suit your identified medical limitations;

  which would enable you to perform your **own occupation** or a **reasonable occupation** (if you are receiving benefits for being unable to work any **reasonable occupation**) and provided that a **physician** agrees that such changes or adaptive equipment suit your medical limitations.

- The date you refuse to receive treatment recommended by your attending **physician** that in Aetna's opinion would: cure; correct; or limit your disability.
- The date your condition would permit you to work, or increase the number of hours you work, or the number or type of duties you perform in your **own occupation**, but you refuse to do so.
- The date of your death.

7263, 7680, 11205-2

A period of disability will end after 24 monthly benefits are payable if it is determined that the disability is primarily caused by:

- a Mental Health or Psychiatric condition, including physical manifestations of these conditions, but excluding those conditions with demonstrable, structural brain damage; or
- Alcohol and/or Drug Abuse.

There are two exceptions which apply if you are confined as an inpatient in a **hospital** or **treatment facility** for treatment of that condition at the end of such 24 months.

- If the inpatient confinement lasts less than 30 days, the period of disability will cease when you are no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of disability may continue until 90 days after the date you have not been so continuously confined.

The Separate Periods of Disability section does not apply beyond 24 months to periods of disability which are subject to the above paragraph.

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How Separate Periods of Disability Are Treated

Once a period of disability has ended, any new period of disability will be treated separately.

However, 2 or more separate periods of disability due to the same or related causes will be deemed to be one period of disability and only one elimination period will apply if:

the separation occurs during the elimination period and the periods are separated by less than 31 days in a row of work.

the separation occurs after the elimination period and the periods are separated by less than 6 months in a row of work.

The first period will not be included if it began while you were not covered under this LTD Plan.

If you become eligible for coverage under any other group long term disability benefits plan carried or sponsored by your Employer, this Separate Periods of Disability section will cease to apply to you.

7537, 7537-1

Other Income Benefits

They are:

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- 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.

7537, 7537-2

- Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:

  Unemployment compensation benefits.

  Temporary or permanent, partial or total disability benefits under any state or federal workers' compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.

  Automobile no-fault wage replacement benefits to the extent required by law.

  Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan.

  Veterans' benefits.

7537, 7537-2

- Statutory disability benefits.

7537, 7537-2

- Disability or unemployment benefits under any plan or arrangement of coverage:

  as a result of employment by or association with the Employer; or

  as a result of membership in or association with any group, association, union or other organization.

  This includes both, plans that are insured and those that are not.

7537, 7537-2

- Unreduced retirement benefits for which you are or may become eligible under a group pension plan at the later of:

  age 62, and

  the Plan's Normal Retirement Age,

  but only to the extent that such benefits were paid for by an employer.

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- Voluntarily elected retirement benefits received under any group pension plan; but only to the extent that such benefits were paid for by an employer.

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- Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.

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- Disability benefits under any group mortgage or group credit disability plan.

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Other income benefits include those, due to your disability or retirement, which are payable to: you; your spouse; your children; your dependents.

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Effect of Increases In Other Income Benefits On Monthly Benefits

Increases in the level of other income benefits due to the following will be considered "other income benefits":

- a change in the number of your family members;
- a recomputation or recalculation to correct or adjust your benefit level as first established for the period of disability; or
- a change in the severity of your disability.

There may be cost of living increases in the level of other income benefits received from a governmental source during a period of disability. These increases will not be deemed to be "other income benefits."

There may be cost of living or general increases in the level of other income benefits from a non-governmental source during a period of disability. These increases will not be considered other income benefits to the extent they are based on the annual average increase in the **Consumer Price Index**.

7539, 7539-1

Other Income Benefits Which Do Not Reduce Monthly Benefits

The amount of any retirement or disability benefits you were receiving from the following sources before the date you become disabled under this LTD Plan will not reduce your monthly benefits:

- military and other government service pensions;
- retirement benefits from a prior employer;
- veterans' benefits for service related disabilities;
- individual disability income policies; and
- Federal Social Security Act.

Also, the amount of any income or other benefits you receive from the following sources will not reduce your monthly benefits:

- profit sharing plans;
- thrift plans;
- 401(k) plans;

- Keogh plans;
- employee stock option plans;
- tax sheltered annuity plans;
- severance pay;
- individual disability income policies; or
- individual retirement accounts (IRAs).

7539, 7539-1

How Aetna Determines Other Income Benefits

Aetna will determine other income benefits as follows:

Lump Sum and Periodic Payments From Any Other Income Benefits

Any lump sum or periodic other income payments that you receive will be prorated on a monthly basis over the period of time for which the payment was made. If a period of time is not indicated, Aetna will prorate the payments over a reasonable period of time, taking into account the expected length of disability benefits and other relevant factors.

That part of the lump sum or periodic payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. If there is no proof acceptable to Aetna as to what that part reasonably is, 50% will be deemed to be for disability.

Any of these "Other Income Payments" that date back to a prior date may be allocated on a retroactive basis.

Estimated Payments

The amount of other income benefits for which you appear to be eligible will be estimated, unless you have signed and returned a reimbursement agreement to Aetna. This agreement contains your promise to repay Aetna for any overpayment of benefits made to you.

If other income benefits are estimated, your monthly benefit will be adjusted when we receive proof:

- of the exact amount awarded; or
- that benefits have been denied after review at the highest administrative level.

Aetna will pay you if any underpayment in your monthly benefit results. You will have to repay Aetna if any overpayment results. When Aetna has to take legal action against you to recover any overpayment, you will also have to pay Aetna's reasonable attorney's fees and court costs, if Aetna prevails.

7538, 11206

Required Proof of Income

Aetna has the right to require proof that:

- you, your spouse, child, or dependent has made application for all other income benefits which you or they are, or may be, eligible to receive relative to your disability and has made a timely appeal of any denial through the highest administrative level; timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial;
- the person has furnished proof needed to obtain other income benefits, which includes, but is not limited to, Workers' Compensation Benefits;
- the person has not waived any other income benefits without Aetna's written consent; and
- the person has sent copies of the documents to Aetna showing the effective dates and the amounts of other income benefits.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless Aetna states, in writing, that it does not require you to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless Aetna relieves you of that obligation.

Aetna also requires proof of income you receive from any occupation for compensation or profit.

You do not have to apply for:

- retirement benefits paid only on a reduced basis; or
- disability benefits under group life insurance if they would reduce the amount of group life insurance;

but, if you do apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

If you do not furnish proof of other income benefits, Aetna reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.

7686; 7543-1

Approved Rehabilitation Program

Aetna retains the right to evaluate you for participation in an **Approved Rehabilitation Program**.

This Plan will pay for all services and supplies, approved in advance by Aetna, needed in connection with such participation; except for those for which you can otherwise receive reimbursement from any third party payor, including any governmental benefits to which you may be entitled.

During your active participation in an Aetna **Approved Rehabilitation Program**, Aetna will pay you an additional 10% of your monthly benefit after all applicable reductions for other income benefits. Not more than a maximum of $ 500 monthly, for a one time maximum of 6 consecutive months for each period of disability will be paid.

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Exclusions

Long Term Disability Coverage does not cover any disability that:

- is due to intentionally self-inflicted **injury** (while sane or insane).
- results from your commission of, or attempting to commit, a criminal act.
- results from driving an automobile while intoxicated. ("Intoxicated" means: the blood alcohol level of the driver of the automobile meets or exceeds the level at which intoxication would be presumed under state law.)
- is due to war or any act of war (declared or not declared).
- is due to: insurrection; rebellion; or taking part in a riot or civil commotion.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- the person will not be deemed to be disabled; and
- no benefits will be payable.

As used above:

"Taking part in a riot" means taking part in any form of public violence, disorder, or disturbance of the peace. At least 3 people must be involved. They do not have to be acting with a common intent. Damage to persons or property or unlawful acts do not have to be intended or result.

"Taking part in a civil commotion" means taking part in any wild or irregular action of an assembly of people which disturbs the civil order.

7541, 7541-1

Pre-existing Conditions

No benefit is payable for any disability that is caused by or contributed to by a "pre-existing condition" and starts before the first to occur of:

- the end of the first 24 months following your effective date of coverage; or
- the end of a period of 12 months in a row, following your effective date of coverage, during which you have received no treatment or services and have taken no prescribed drugs or medicines for that condition.

A disease or **injury** is a pre-existing condition if, during the 12 months before your effective date of coverage:

- it was diagnosed or treated; or
- services were received for the diagnosis or treatment of the disease or **injury**; or
- you took drugs or medicines prescribed or recommended by a **physician** for that condition.

Special Rules As To An Increase in Coverage

The Scheduled Benefit will be determined by the benefit amount in effect immediately before an increase for any disability that is caused by or contributed to by a "pre-existing condition" and starts before:

- the end of the first 24 months following the effective date of an increase in coverage; or if earlier;
- the end of a period of 12 months in a row, following your effective date of an increase in coverage, during which you have received no treatment or services and have taken no prescribed drugs or medicines for that condition.

A disease or **injury** is a pre-existing condition if, during the 12 months before your effective date of an increase in coverage:

- it was diagnosed or treated; or
- services were received for the diagnosis or treatment of the disease or **injury**; or
- you took drugs or medicines prescribed or recommended by a **physician** for that condition.

No benefit is payable if the disability is excluded by any other terms of this Plan.

7541-2; 11522

General Information About Your Coverage

(including information about Termination of Coverage and the Effect of Prior Coverage)

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Ceasing active work will be deemed to be cessation of employment. If you are not at work due to one of the following, employment may be deemed to continue up to the limits shown below.

If you are not at work due to disease or **injury**, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.

If you are not at work due to a leave of absence, your employment may be continued until stopped by your Employer, but not beyond 12 months from the start of the absence.

If you are not at work due to temporary lay-off, your employment will be deemed to cease on your last full day of active work before the start of the lay-off .

In figuring when employment will stop for the purposes of termination of any coverage, Aetna will rely upon your Employer to notify Aetna. This can be done by telling Aetna or by stopping premium payments. Your employment may be deemed to continue beyond any limits shown above if Aetna and your Employer so agree in writing.

Benefits May Continue After Termination

If your coverage ceases during a period of disability which began while you had coverage, benefits will be available as long as your period of disability continues.

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Reinstatement of Coverage

If your coverage terminates, you may again become covered in accordance with the terms of this Plan; except that:

- If:

  you return to active work within 6 months of the date coverage terminated; and

  you request coverage from your Employer within 31 days of your return to active work;

  any Limitation as to a pre-existing condition will apply only to the extent it would have applied if your coverage had not terminated. Also, any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

- If:

  you return to active work between the 7th and the 24th month following the date coverage terminated; and

  you request coverage from your Employer within 31 days of your return to active work;

any period of continuous service required before your Eligibility Date will apply only to the extent it would have applied if coverage had not terminated.

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How "Prior Coverage" Affects Coverage Under This Plan

If the coverage of any person under this Plan replaces any prior coverage of the person, the following will apply.

"Prior coverage" is any plan of group long term disability coverage that has been replaced by coverage under part or all of this Plan. It must have been sponsored by your Employer who is participating in this Plan. The replacement can be complete or in part for the Eligible Class to which you belong. Any such plan is prior coverage if provided by another group insurance plan.

A person's coverage under this Plan replaces and supersedes any prior coverage. It will be in exchange for everything under such prior coverage except coverage will not be available as to a particular period of disability for which a benefit is available or would be available under the prior coverage in the absence of coverage under this Plan.

As stated earlier, this Plan has a Limitation as to a disability caused by a pre-existing condition.

However, if:

- you had prior coverage on the day before Long Term Disability Coverage took effect; and
- you became covered for this LTD Plan on the date it takes effect;

such Limitation applies only until a continuous period of coverage under the prior coverage and this LTD Plan are equal to the lesser of:

- 12 months in a row during which you have received no treatment or services and taken no prescribed drugs or medicines for that pre-existing condition;
- 24 months; and
- any period of limitation as to a pre-existing condition remaining under the prior coverage.

Where the Limitation no longer applies, the amount of monthly benefit and the maximum period for which benefits will be payable, as to a period of disability caused by such pre-existing condition, will be as provided in this LTD Plan.

In no event will:

- a benefit be payable as to a period of disability caused by a pre-existing condition, if the disability is excluded by any other terms of this LTD Plan; or
- a condition be considered to be a pre-existing condition under this LTD Plan if it was not a pre-existing condition under the prior coverage.

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Survivor Benefit

If you die while disabled, a single, lump sum benefit will be paid under this provision if:

- there is an Eligible Survivor as defined below; and
- a Monthly Benefit was payable under this Plan.

The benefit amount will be:

- 3 times the Monthly Benefit, not reduced by other income benefits, for which you were eligible in the full month just before the month in which you die.

If you die before you are eligible for one full Monthly Benefit, however, the benefit will be:

- 3 times the Monthly Benefit, not reduced by other income benefits for which you would have been eligible if you had not died, for the first full month after the month in which you die.

An Eligible Survivor is:

- Your legally married spouse at the date of your death.
- If there is no such spouse, your biological or legally adopted child who, when you die:

  is not married; and

  is depending mainly on you for support; and

  is under age 25. This age limit will not apply if the child is not capable of self-sustaining employment because of mental or physical handicap which existed prior to age 25.

How the Survivor Benefit Will Be Paid

The benefit will be paid as soon as the necessary written proof of your death and disability status is received.

The benefit will be paid to your eligible surviving spouse, if any. Otherwise, it will be paid in equal shares to your eligible surviving children.

If Monthly Benefit payments are made in amounts greater than the Monthly Benefits that you are entitled to receive, Aetna has the right to first apply the survivor benefit to any such overpayment.

Aetna may pay the benefit to anyone who, in Aetna's opinion, is caring for and supporting the eligible survivor; or, if proper claim is made, Aetna may pay the benefit to an eligible survivor's legally appointed guardian or committee.

7494, 7494-2

Assignment of Insurance

Coverage may be assigned only with the consent of Aetna.

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How and When To Report Your Claim

You are required to submit a claim to Aetna by following the procedure chosen by your Employer. If the procedure requires that claim forms be submitted, they may be obtained at your place of employment or from Aetna. Your claim must give proof of the nature and extent of the loss. Aetna may require copies of documents to support your claim, including data about any other income benefits. You must also provide Aetna with authorizations to allow it to investigate your claim and your eligibility for and the amount of other income benefits.

You must furnish such true and correct information as Aetna may reasonably request.

The deadline for filing a claim for benefits is 90 days after the end of the elimination period. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will be accepted if you file as soon as possible; but not later than 1 year after the deadline unless you are legally incapacitated. Otherwise, late claims will not be covered.

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How Benefits Will Be Paid

Benefits will be paid to you at the end of each calendar month during the period for which benefits are payable. Benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Any unpaid balance at the end of Aetna's liability will be paid within 30 days of receipt by Aetna of the due written proof.

Aetna may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

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Examinations and Evaluations

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable. This will be done at Aetna's expense.

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Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

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Recovery of Benefits Paid (Subrogation)

As a condition to paying or providing any disability benefits under this Plan, the Plan shall be subrogated to (has the right to pursue) all rights of recovery you have against any third party with respect to such disability, to the extent of benefits provided. The term "third party" includes any party possibly responsible for your injuries or illnesses, or your no-fault automobile insurance coverage.

The following terms and provisions shall apply with regard to the Plan's right of recovery:

- you shall not prejudice the Plan's subrogation rights in any way;
- you shall cooperate fully with the Plan's efforts to recover its benefits paid;
- you shall notify Aetna within 45 days of the date when any notice is given to any other party (including an attorney) of any intention to pursue or investigate a claim to recover damages due to: injuries; or illnesses; that you sustained;
- the Plan's subrogation rights are a first priority claim against all potential liable parties and are to be paid before any other claim for your damages. This applies even if the remainder of the payments from such third party is insufficient to make you whole or compensate you: in part; or in whole for the damages that you sustained.

This provision will apply regardless of whether:

- liability for payment is admitted by the third party; or
- the settlement or judgment you receive identifies the specific benefits this Plan provided.

Recovery of Overpayments

If payments are made in amounts greater than the benefits that you are entitled to receive, Aetna has the right to do any one or all of the following:

- to require you to return the overpayment on request;
- to stop payment of benefits until the overpayment is recovered;
- to take any legal action needed to recover the overpayment; and
- to place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

If the overpayment:

- occurs as a result of your receipt of other income benefits for the same period for which you have received a benefit under this Plan; and
- to obtain such other income benefits, advocate or legal fees were incurred;

Aetna will exclude from the amount to be recovered, such advocate or legal fees; provided you return the overpayment to Aetna within 30 days of Aetna's written request for the overpayment. If you do not return the overpayment to Aetna within such 30 days, such fees will not be excluded; you will remain liable for repayment of the total overpaid amount.

Examples of other income referred to in the preceding paragraph are:

- Workers' compensation.

- Federal Social Security benefits.
- Disability payments which result from the act or omission of any person whose action caused your disability.

11211; 7543

Contract Not a Substitute for Workers' Compensation Insurance

The group contract is not in lieu of and does not affect workers' compensation benefits. However, any workers' compensation benefits are considered other income benefits.

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General Provisions

The following additional provisions apply to your coverage.

You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer or, if you prefer, from the Home Office of Aetna. Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued with respect to all or any class of employees.

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Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Adjusted Predisability Earnings

This is your **predisability earnings** plus any increase made on each January 1, starting on the January 1 following 12 months of a period of disability. The increase on each such January 1 will be by the percentage increase in the **Consumer Price Index**, rounded to the nearest tenth; but not by more than 10%.

Approved Rehabilitation Program

This is a written program approved by Aetna which provides for services and supplies that are intended to enable you to return to work. This program may include, but is not limited to:

- vocational testing;
- vocational training;
- alternative treatment plans such as:

  support groups;
  physical therapy;
  occupational therapy;
  speech therapy;

- workplace modification to the extent not otherwise provided;
- part time employment; and
- job placement.

A rehabilitation program will cease to be **An Approved Rehabilitation Program** on the date Aetna withdraws, in writing, its approval of the program.

Consumer Price Index

The CPI-W, Consumer Price Index for Urban Wage Earners and Clerical Workers is published by the United States Department of Labor. If the CPI-W is discontinued or changed, Aetna reserves the right to use a comparable index.

Effective Treatment of Alcoholism or Drug Abuse

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- has a follow-up therapy program directed by a **physician** on at least a monthly basis; or
- includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means solely treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means primarily providing an environment free of alcohol or drugs.

Hospital

This is an institution that:

- mainly provides, on an inpatient basis, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons; and
- is supervised by a staff of **physicians**; and
- provides 24 hour a day registered nursing (RN) service; and
- is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

An institution which does not provide complete surgical services, but which meets all the other tests listed above, will also be deemed a hospital if:

- it provides services chiefly to patients all of whom have conditions related either by a medical specialty field or a specific disease category; and
- while confined, the patient is under regular therapeutic treatment by a **physician** for the **injury** or disease.

Injury
An accidental bodily injury.

Material Duties
These are duties that:

- are normally required for the performance of your **own occupation**; and
- cannot be reasonably: omitted or modified. However, to be at work in excess of 40 hours per week is not a material duty.

Own Occupation
This is the occupation that you are routinely performing when your period of disability begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed:

- for your specific employer; or
- at your location or work site; and

without regard to your specific reporting relationship.

Physician
"Physician" means a person who is a legally qualified physician. Also, to the extent required by law, a practitioner who performs a service for which coverage is provided when it is performed by a physician.

Regular care of a physician means you are attended by a physician:

- who is not you or related to you;
- who is practicing within the scope of his or her license;
- who has the medical training and clinical expertise suitable to treat your disabling condition;
- who specializes in psychiatry, if your disability is caused, to any extent, by a mental health or psychiatric condition; and
- whose treatment is:

  consistent with the diagnosis of the disabling condition; and
  according to guidelines established by medical, research and rehabilitative organizations; and
  administered as often as needed.

Predisability Earnings
This is the amount of salary or wages you were receiving from an employer participating in this Plan on the day before a period of disability started, calculated on a monthly basis.

It will be figured from the rule below that applies to you.

If you are paid on an annual contract basis, your monthly salary is 1/12th of your annual contract salary.

If you are paid on an hourly basis, the calculation of your monthly wages is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month; but not more than 173 hours per month.

If you do not have regular work hours, the calculation of your monthly salary or wages is based on the average number of hours you worked per month during the last 12 calendar months (or during your period of employment if fewer than 12 months); but not more than 173 hours per month.

Included in salary or wages are:

- Contributions you make through a salary reduction agreement with your Employer to any of the following:

  An Internal Revenue Code (IRC) Section 125 plan for your fringe benefits.

  An IRC 401(k), 403(b), or 457 deferred compensation arrangement.

  An executive nonqualified deferred compensation agreement.

Not included in salary or wages are:

- Commissions
- Awards and bonuses.
- Overtime pay.
- Contributions made by your Employer to any deferred compensation arrangement or pension plan.

A retroactive change in your rate of earnings will not result in a retroactive change in coverage.

Reasonable Occupation

This is any gainful activity for which you are; or may reasonably become; fitted by: education; training; or experience; and which results in; or can be expected to result in; an income of more than 80% of your **adjusted predisability earnings**.

Treatment Facility

This is an institution (or distinct part thereof) that is for the treatment of alcoholism or drug abuse and which meets fully every one of the following tests:

- It is primarily engaged in providing on a full-time inpatient basis, a program for diagnosis, evaluation, and treatment of alcoholism or drug abuse.
- It provides all medical detoxification services on the premises, 24 hours a day.
- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the alcoholism or drug abuse, on a 24 hour daily basis. Also, it provides, or has an agreement with a **hospital** in the area to provide, any other medical services that may be required during the treatment period.
- On a continuous 24 hour daily basis, it is under the supervision of a staff of **physicians**, and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.
- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a **physician**.
- It meets any applicable licensing standards established by the jurisdiction in which it is located.

Conversion Privilege

If your coverage under the Plan ends because your employment ceases, you may be eligible to convert your monthly benefits of your LTD coverage. No evidence of insurability is needed.

To be eligible to convert, you must:

- have been insured under this Plan for twelve consecutive months immediately prior to the date your employment ceased (the time you were covered under the Plan, and any other Plan of your Employer's which it replaced, will be considered in determining your eligibility to convert); and
- apply for conversion coverage in writing and submit the first premium payment to Aetna within 31 days after coverage under the Plan ceases.

Coverage under the group conversion policy will take effect on the day after coverage under this Plan ceased.

If you are eligible to convert, the disability benefits and the amount of disability coverage you will be eligible for will be those offered by Aetna, in accordance with its established guidelines and practices. The disability benefits and amount of disability coverage under the conversion coverage will not be the same as those you were eligible for under this Plan.

You may not convert your monthly benefits of your LTD coverage under this Plan if:

- You were not covered under the Plan for at least 12 consecutive months.
- Your coverage under the Plan terminated for any of the following reasons:
  the group policy under which the Plan is provided terminates;
  the Plan is amended to exclude the class of employees to which you belong;
  you no longer are in a class of employees eligible for coverage under the Plan;
  you retire (you retire when you receive payments from the Employer's retirement plan as recognition of past services, or if you have concluded your working career).
- Your coverage under the Plan ceased because you failed to make any required contribution when due.
- You become covered for LTD coverage under another employer group plan within 31 days after your coverage under this Plan ceased.
- Your certified period of disability ends and you do not return to work with the Employer.
- You are unable to work due to a mental or physical condition.
- You are on leave of absence.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law.

Some of the ways in which personal information is used include claim payment; utilization review and management; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Information Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call 1-866-825-6944 or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, your Employer may allow you to continue coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

Claim Procedures

Your booklet-certificate contains information on reporting claims. Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

Note: If applicable state law requires the Plan to take action on a claim or appeal within a shorter timeframe, the shorter period will apply.

Filing Disability Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of an adverse benefit determination not later than 45 days after receipt of the claim. This time period may be extended up to an additional 30 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 45 day period. If a decision cannot be made within this 30 day extension period due to circumstances outside the Plan's control, the time period may be extended up to an additional 30 days, in which case you will be notified before the end of the first 30 day extension period. The notice of extension will explain the standards on which entitlement to a benefit are based, the unresolved issues that prevent a decision, and the additional information needed to resolve those issues. You will be given at least 45 days after receiving the notice to furnish that information.

Filing of an Appeal of an Adverse Benefit Determination for a Disability Claim

You will have 180 days following receipt of an adverse benefit decision to appeal the decision. You will ordinarily be notified of the decision not later than 45 days after the appeal is received. If special circumstances require an extension of time of up to an additional 45 days, you will be notified of such extension during the 45 days following receipt of your request. The notice will indicate the special circumstances requiring an extension and the date by which a decision is expected.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records, and other information relevant to the claim.