The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer’s coverage under the Group Policy. If the terms of this Certificate and Summary Plan Description differ from the terms of your Employer’s coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate and Summary Plan Description or other notice to be given to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section headings, and references to them, appear in boldface type.

Chairman, President and CEO
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COVERAGE FEATURES

This section contains many of the features of your short term disability (STD) insurance. Other provisions, including exclusions, limitations, and Deductible Income appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

<table>
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“Days” mean calendar days, unless otherwise noted. “Writing” includes a form signed by you, or a verification from the Policyholder or the Policyholder’s designated agent, of an electronic or telephonic communication by you.

Member means one of the following:

1. A regular full-time staff member of the Employer with less than 2 years of benefits eligible service with the Employer who is Actively At Work at least 35 hours each week;
2. A regular full-time faculty member of the Employer with less than 2 years of benefits eligible service with the Employer who is Actively At Work at least 20 hours each week;
3. A regular part-time staff member or part-time faculty member of the Employer who is Actively At Work at least 14 hours each week; or
4. A regular medical resident of the Employer who is Actively At Work for the Employer.

For purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days.

Member does not include a temporary or seasonal employee, a leased employee, or an independent contractor.

Class Definition: None

SCHEDULE OF INSURANCE

Active Full-time Staff Members, Full-Time Faculty Members, Part-time Faculty Members And Residents:
You are eligible on the later of (A) the Group Policy Effective Date, and (B) the first day of the calendar month coinciding with or next following the date you become a Member.

Active Part-Time Staff Members:
You are eligible on the later of (A) the Group Policy Effective Date, and (B) the first day of the calendar month coinciding with or next following 6 consecutive months as a Member.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance.
The maximum Leave Of Absence Periods are as follows:

1. If you are on a Leave Of Absence for the purpose of either full-time study for an advanced degree, or work in the field of education or research such as a Fulbright Award, foundation grant, government project, or other academic research related to your field of expertise, your insurance may be continued to the end of 12 months, or, if earlier, the end of such leave.

2. If you are on a Leave Of Absence for the purpose of a medical resident leave, your insurance may be continued to the end of 24 months, or, if earlier, the end of such leave.

3. If you are on a Leave Of Absence due to a family or medical leave and continuation of insurance is required by a state-mandated family or medical leave act or law, your insurance may be continued to the end of 6 months, or, if later, the period required by the state act or law.

4. If you are on any other Leave Of Absence, your insurance may be continued to the end of 12 months, or if earlier, the period approved by your Employer.

Leave Of Absence means a period when you are absent from Active Work during which your insurance under the Group Policy will continue and employment will be deemed to continue, solely for the purposes of determining when your insurance ends, provided the required premiums for you are remitted and such a leave of absence for you is approved by your Employer and, at the end of the absence:

a. You are scheduled to return to Active Work;

b. You are retiring under the Employer’s voluntary incentive retirement program; or

c. Your employment is terminating under the terms of a negotiated severance agreement.

During a Leave Of Absence your Predisability Earnings and your Own Occupation will be based on what was in effect on your last day of Active Work immediately before the start of your Leave Of Absence.

STD Benefit: 60% of the first $5,000 of your Predisability Earnings, reduced by Deductible Income.

Maximum: $3,000 before reduction by Deductible Income.

Minimum: $25

Benefit Waiting Period:

For Disability caused by accidental Injury: 30 calendar days

For Disability caused by Physical Disease, Pregnancy or Mental Disorder: 30 calendar days

Enrollment Period for Contributory insurance:

If you do not apply within 30 calendar days of becoming eligible, you may only apply during your Employer's Annual Enrollment Period or within 30 days of a Family Status Change, and you will be required to submit Evidence of Insurability to become insured.

Maximum Benefit Period: 150 calendar days. However, STD Benefits will end on the date long term disability benefits become payable to you under a group plan provided by your Employer, even if that occurs before the end of the Maximum Benefit Period.
If you are Disabled for less than one full week, we will pay one-seventh of the STD Benefit for each day of Disability.

Annual Enrollment Period means the period designated each year by your Employer when you may change insurance elections.

Family Status Change means a Change of Status as defined under your Employer's IRC Section 125 Cafeteria Plan. The change must be allowed by your Employer's IRC Section 125 Cafeteria Plan

PREMIUM CONTRIBUTIONS

Insurance is: Contributory

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan: Short Term Disability Insurance

Name, Address of Plan Sponsor: The George Washington University
45155 Research Place, Suite 160
Ashburn VA 20147

Plan Sponsor Tax ID Number: 53-0196584

Plan Number: 505

Type of Plan: Group Insurance Plan

Type of Administration: Contract Administration

Name, Address, Phone Number of Plan Administrator: Plan Administration Committee
The George Washington University
45155 Research Place, Suite 160
Ashburn VA 20147
(703) 726-8546

Name, Address of Registered Agent for Service of Legal Process: Mary Lynn Reed, Esq.
The George Washington University
Office of the Senior Vice President and General Counsel
2100 Pennsylvania Ave. N.W., Suite 250
Washington, DC 20052

If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To: Standard Insurance Company
1100 SW 6th Ave
Portland OR 97204-1093

Sources of Contributions: Member

Funding Medium: Standard Insurance Company - Fully Insured

Plan Fiscal Year End: December 31
INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay STD Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

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BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in Active Work Provisions and When Your Insurance Becomes Effective.

You are a Member if you are one of the following:

1. A regular full-time staff member of the Employer with less than 2 years of benefits eligible service with the Employer who is Actively At Work at least 35 hours each week;
2. A regular full-time faculty member of the Employer with less than 2 years of benefits eligible service with the Employer who is Actively At Work at least 20 hours each week;
3. An regular part-time staff member or part-time faculty member of the Employer who is Actively At Work at least 14 hours each week; or
4. A regular medical resident of the Employer who is Actively At Work for the Employer.

For purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as you are capable of Active Work on those days.

You are not a Member if you are a temporary or seasonal employee, a leased employee, or an independent contractor.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the Coverage Features.

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WHEN YOUR INSURANCE BECOMES EFFECTIVE

A. When Insurance Becomes Effective

You must apply in writing for insurance and agree to pay premiums.

Subject to the Active Work Provisions, your insurance becomes effective as follows:

1. Insurance Subject To Evidence Of Insurability

   Insurance subject to Evidence Of Insurability becomes effective on the first day of the calendar month following the date we approve your Evidence Of Insurability.

2. Insurance Not Subject To Evidence Of Insurability

   Insurance not subject to Evidence Of Insurability becomes effective on:

   The first day of the calendar month coinciding with or next following the date you apply, if you apply during the first 30 days after you become eligible, as shown in the Eligibility Waiting Period.

   Late application: Evidence Of Insurability is required if you apply more than 30 days after you become eligible, as shown in the Eligibility Waiting Period. However if you do not apply during the first 30 days after you become eligible, you may only apply during an Annual Enrollment Period or with 30 days of a Family Status Change.

B. Takeover Provision
If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.

C. Evidence Of Insurability Requirement

Evidence Of Insurability satisfactory to us is required:

a. For late application for Contributory insurance.

b. For Members eligible but not insured for Contributory insurance under the Prior Plan.

c. For reinstatements if required. This requirement is waived if you apply for reinstatement of insurance following a family or medical leave or any other leave for disability.

Providing Evidence Of Insurability means you must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about your health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about your insurability that we may reasonably require.

ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing with reasonable continuity the Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Insurance

This Active Work requirement also applies to any increase in your insurance.

WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your insurance.
2. The date the Group Policy terminates.
3. The date your employment terminates.
4. The date you cease to be a Member. However, your insurance will be continued during the following periods when you are absent from Active Work, unless it ends under any of the above.
   a. During the first 90 days of a temporary or indefinite involuntary administrative leave of absence or sick leave, provided your Employer is paying you at least the same Predisability Earnings paid to you immediately before you ceased to be a Member. A period when you are absent from Active Work as part of a severance or other employment termination agreement is not a leave of absence, even if you are receiving the same Predisability Earnings.
b. During any other temporary leave of absence approved by your Employer in advance and in writing, but not to exceed the applicable Leave Of Absence Period shown in the Coverage Features. A period of Disability is not a leave of absence.

c. During the Benefit Waiting Period and while STD Benefits are payable.

**CONTINUED INSURANCE DURING SCHOOL VACATIONS**

If you cease to be a Member because of a school break or vacation, your insurance will be continued during that period.

**REINSTATEMENT OF INSURANCE**

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If you cease to be a Member because of a Disability that is not covered solely because of the exclusion for work related Disabilities, your insurance will end. However, if you become a Member again immediately after workers’ compensation temporary benefits end, the Eligibility Waiting Period will be waived.

2. If your insurance ends because you cease to be a Member for any reason other than item 1 above, and if you become a Member again within 365 days, the Eligibility Waiting Period will be waived.

3. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.

4. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.

5. In no event will insurance be retroactive.

**DEFINITION OF DISABILITY**

You are Disabled if you meet the following Own Occupation definition of Disability.

You are required to be Disabled only from your Own Occupation. You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:

1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and

2. You suffer a loss of at least 20% in your Predisability Earnings when working in your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

You may work in another occupation while you meet the Own Occupation definition of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation exceed 80% of your Predisability Earnings.

Your Work Earnings may be Deductible Income. See Return To Work Provisions and Deductible Income.
Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by employers from those engaged in a particular occupation, that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

RETURN TO WORK PROVISIONS

A. Return To Work Responsibility

No STD Benefits will be paid for any period of Disability when you are able to work in your Own Occupation and able to earn at least 20% of your Predisability Earnings, but you elect not to work.

B. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Own Occupation definition of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if STD Benefits are payable on that date.

Your Work Earnings will be Deductible Income as determined in 1., 2. and 3.

1. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.
2. Determine 100% of your Predisability Earnings.
3. If 1. is greater than 2., the difference will be Deductible Income.

C. Work Earnings Definition

Work Earnings means your gross weekly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available in your Own Occupation. Work Earnings includes sick pay, vacation pay, annual or personal leave pay or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than weekly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:
1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.
2. Will not be limited to the taxable income you report to the Internal Revenue Service.
3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.
4. May ignore depreciation as a deduction from your gross earnings.
5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.
If we determine that your earnings vary substantially from week to week, we may determine your Work Earnings by averaging your earnings over the most recent four-week period. You will no longer be Disabled when your average Work Earnings over the last four weeks exceed 80% of your Predisability Earnings.

**REASONABLE ACCOMMODATION EXPENSE BENEFIT**

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, we will pay that employer a Reasonable Accommodation Expense Benefit in an amount agreed to by us, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

**TEMPORARY RECOVERY**

You may temporarily recover from your Disability during the Maximum Benefit Period, and then become Disabled again from the same cause or causes, without having to serve a new Benefit Waiting Period. Temporary Recovery means you cease to be Disabled for no longer than the applicable Allowable Period. See **Definition Of Disability**.

A. Allowable Period

The Allowable Period of recovery during the Maximum Benefit Period is: a total of 14 days of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Period, the following will apply.

1. The Predisability Earnings used to determine your STD Benefit will not change.
2. The period of Temporary Recovery will not count toward your Maximum Benefit Period.
3. No STD Benefits will be payable for the period of Temporary Recovery.
4. No STD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured during your period of recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

**WHEN STD BENEFITS END**

Your STD Benefits end automatically on the earliest of:

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date long term disability benefits become payable to you under a group long term disability policy, even if that occurs before the end of the Maximum Benefit Period.
5. The date benefits become payable to you under any other disability insurance plan under which you become insured through employment during a period of Temporary Recovery.

6. The date you fail to provide proof of continued Disability and entitlement to STD Benefits.

**PREDISABILITY EARNINGS**

Your Predisability Earnings will be based on your annual benefits salary, in effect on your last full day of Active Work. Any subsequent change in your earnings after that last full day of Active Work will not affect your Predisability Earnings.

Predisability Earnings means your annual benefits salary from your Employer divided by 52, including:

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.

2. Amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

Predisability Earnings does not include:

1. Bonuses.
2. Commissions.
3. Overtime pay.
5. Stock options or stock bonuses.
6. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
8. Any other extra compensation.

**DEDUCTIBLE INCOME**

Subject to Exceptions To Deductible Income, Deductible Income means:

1. Sick pay, annual or personal leave pay, severance pay, or other salary continuation, paid to you by your Employer, if it exceeds the amount found in a., b., and c.
   a. Determine the amount of your STD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.
   b. Determine 100% of your Predisability Earnings.
   c. If a. is greater than b., the difference will be Deductible Income.
2. Your Work Earnings, as described in the Return To Work Provisions.
3. Any amount you receive or are eligible to receive because of your disability under a state disability income benefit law or similar law.
4. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.

5. Any disability or retirement benefits you receive under your Employer’s retirement plan.

6. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while STD Benefits are payable.

7. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

8. Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgment, settlement or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.

9. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.

2. Reimbursement for hospital, medical, or surgical expense.

3. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.

4. Benefits from any individual disability insurance policy.

5. Group credit or mortgage disability insurance benefits.

6. Accelerated death benefits paid under a life insurance policy.

7. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.

8. The following amounts under your Employer’s retirement plan:
   a. A lump sum distribution of your entire interest in the plan.
   b. Any amount which is attributable to your contributions to the plan.
   c. Any amount you could have received upon termination of employment without being disabled or retired.
RULES FOR DEDUCTIBLE INCOME

A. Weekly Equivalents

Each week we will determine your STD Benefit using the Deductible Income for the same weekly period, even if you actually receive the Deductible Income in another week.

If you are paid Deductible Income in a lump sum or by a method other than weekly, we will determine your STD Benefit using a prorated amount. We will use the period of time to which the Deductible Income applies. If no period of time is stated, we will use a reasonable one.

B. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be eligible. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request. Otherwise, we may reduce your STD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us. You will not receive any STD Benefits until we have been repaid in full. In the meantime, any STD Benefits paid, including the Minimum STD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

SUBROGATION

If STD Benefits are paid or payable to you under the Group Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery you may have in respect to such act or omission. You must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. You must avoid doing anything that would prejudice our rights of subrogation.

If you notify us before filing suit or settling your claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of STD Benefits, and such notice shall constitute a lien on any judgment recovered.

If you or your legal representative fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in your name. We are entitled to retain from any judgment recovered the amount of STD Benefits paid or to be paid to you or on your behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, shall be paid to you or as the court may direct.

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay STD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive STD Benefits will not be affected by:
1. Any amendment to the Group Policy that is effective after you become Disabled; or
2. Termination of the Group Policy after you become Disabled.

**EFFECT OF NEW DISABILITY**

If a period of Disability is extended by a new cause while STD Benefits are payable, STD Benefits will continue while you remain Disabled. However, 1 and 2 below will apply.

1. STD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. All provisions of the Group Policy, including the **Disabilities Excluded From Coverage** and **Limitations** sections, will apply to the new cause of Disability.

**DISABILITIES EXCLUDED FROM COVERAGE**

A. War

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

C. Work Related

You are not covered for a Disability arising out of or in the course of any employment for wage or profit.

D. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

E. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

**LIMITATIONS**

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No STD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Occupational Benefits

No STD Benefits will be paid for any period when you are eligible to receive benefits for your Disability under a workers' compensation law or similar law. If your claim for these benefits is
accepted, compromised or settled (whether disputed or undisputed), you must repay us for the full amount of any payments we make to you while your claim for occupational benefits is pending.

C. Imprisonment

No STD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

D. Return To Work Responsibility

No STD Benefits will be paid for any period of Disability when you are able to work in your Own Occupation and able to earn at least 20% of your Predisability Earnings, but you elect not to work.

E. Rehabilitation Program

No STD Benefits will be paid for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If you do not receive our forms within 15 days after you ask for them, you may submit your claim in a letter to us. The letter should include the date Disability began, and the cause and nature of the Disability.

B. Time Limits On Filing Proof Of Loss

You must give us Proof Of Loss within 90 days after the end of the Benefit Waiting Period. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to STD Benefits. Proof Of Loss must be provided at your expense.

For claims of Disability due to conditions other than Mental Disorders, we may require proof of physical impairment that results from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

D. Documentation

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend STD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

We will pay STD Benefits within 60 days after you satisfy Proof Of Loss.
STD Benefits will be paid to you at the end of each week you qualify for them. STD Benefits remaining unpaid at your death will be paid to your estate.

G. Notice Of Decision On Claim

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Reference to any internal rule or guideline relied upon in making our decision.

d. A description of any additional information needed to support your claim.

e. Information concerning your right to a review of our decision.

f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

H. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.
If we extend the review period, we will notify you of the following: (a) the reasons for the extension; 
(b) when we expect to decide your claim on review; and (c) any additional information we need to 
decide your claim.

If we request additional information, you will have 45 days to provide the information. If you do 
not provide the requested information within 45 days, we may conclude our review of your claim 
based on the information we have received.

If we deny any part of your claim on review, you will receive a written notice of denial containing:
a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents 
and records relevant to your claim.
e. Information concerning your right to bring a civil action for benefits under section 502(a) of 
ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you 
may contact your local U.S. Department of Labor Office and your State insurance regulatory 
agency for assistance.

I. Assignment

The rights and benefits under the Group Policy are not assignable.

ST.CL.OT.2

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or 
Employer, we have full and exclusive authority to control and manage the Group Policy, to administer 
claims, and to interpret the Group Policy and resolve all questions arising in its administration, 
interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the Group Policy 
   and any claim under it;

3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable;
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., 
      or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our 
authority is conclusive and binding.

ST.AL.OT.1
TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

ST.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement you make to obtain or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any person claiming benefits a copy of the signed written instrument which contains your misrepresentation.

After insurance has been in effect for two years, during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of The Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty. No misrepresentation by the Policyholder or your Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

ST.IN.OT.1

CLERICAL ERROR, AGENCY AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.
C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and
2. The difference between the amount paid and the amount which would have been paid if the age had been correctly stated.

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before STD Benefits become payable. No STD Benefits are payable for the Benefit Waiting Period. See Coverage Features.

Contributory means insurance is elective and Members pay all or part of the premium for insurance.

Employer means an employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group STD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.

Injury means an injury to the body.

L.L.C. Owner-Employee means an individual who owns an equity interest in an Employer and is actively employed in the conduct of the Employer’s business.

Maximum Benefit Period means the longest period for which STD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit Waiting Period. No STD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See Coverage Features.
Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Noncontributory means (a) insurance is nonelective and the Policyholder or Employer pay the entire premium for insurance; or (b) the Policyholder or Employer require all eligible Members to have insurance and to pay all or part of the premium for insurance.

P.C. Partner means the sole active employee and majority shareholder of a professional corporation in partnership with the Policyholder.

Physical Disease means a physical disease entity or process that produces structural or functional changes in your body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer’s group short term disability insurance plan in effect on the day before the effective date of your Employer’s coverage under the Group Policy and which is replaced by the Group Policy.

STD Benefit means the weekly benefit payable to you under the terms of Group Policy.

**ERISA INFORMATION AND NOTICE OF RIGHTS**

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA)

A. General Plan Information

   The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Statement Of Your Rights Under ERISA

   1. Right To Examine Plan Documents

      You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

   2. Right To Obtain Copies Of Plan Documents

      You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

   3. Right To Receive A Copy Of Annual Report

      The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.
4. Right To Review Of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

C. Obligations Of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan 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 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.

E. Plan And ERISA Questions

If you have any questions about the 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, 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, DC 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.

DC/STDC2000
Residents of the District of Columbia who purchase health insurance, life insurance and annuities, should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted below.

**DISTRICT OF COLUMBIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

**DISCLAIMER**

The District of Columbia Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limitations and exclusions. Coverage is generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Act of 1992 when selecting an insurer.

Policyholders with additional questions may contact:

**Executive Director**
Mr. Robert M. Willis
The District of Columbia Life and Health Insurance Guaranty Association
1290 G Street, N.W., Suite 800
Washington, D.C. 20005
Phone: (202) 434-8771
Fax: (202) 347-2990

**Insurance Commissioner**
Mr. Laurence H. Mirel
District of Columbia Department of Insurance and Securities Regulation
810 1st Street, N.E., Suite 701
Washington, D.C. 20002
Phone: (202) 727-8000
Phone (202) 535-1196

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.
Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance or annuity contract issued by a member insurer, or if they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

**EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside of that state of incorporation);
- their insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service plan, a health maintenance organization or a risk retention group.

The Guaranty Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- interest rate guarantees which exceed certain statutory limitations;
- dividends, experience rating credits or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or
- unallocated annuity contracts.

**LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of either the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or, with respect to any one life, regardless of the number of policies, contracts or certificates, in the case of life insurance, $300,000 in death benefits but not more than $100,000 in net cash surrender or net cash withdrawal values; in the case of health insurance, $100,000 in health insurance benefits; and with respect to annuities, $300,000 in the present value of annuity benefits. Finally, in no event is the Guaranty Association liable for more than $300,000 with respect to any one individual.