Group Voluntary Short Term Disability Insurance

Designed for Class 1 and Class 2 Employees of

The Johns Hopkins University

by

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Simsbury, Connecticut
(A stock insurance company)

Having issued Group Policy No. 371107 (83148115)

to

The Johns Hopkins University

(herein called the Employer)

CERTIFICATE OF INSURANCE

CERTIFIES that *You* are insured provided that *You* qualify under the ELIGIBILITY provision, become insured and remain insured in accordance with the terms of the policy. *Your* insurance is subject to all the definitions, limitations and conditions of the policy. It takes effect on the effective date stated in the EFFECTIVE DATE provision. All periods of insurance begin and end at 12:01 a.m., Standard Time, at the Employer's address on the effective date stated in the EFFECTIVE DATE provision.

This certificate describes *Your* eligibility for benefits and the terms and provisions of the policy. It replaces and cancels any other certificate previously issued to *You* under the policy.
CDI-1AB19

Signed for Hartford Life and Accident Insurance Company

Terence Shields, *Secretary* **Ronald R. Gendreau, *President***

Group Short Term Disability Certificate

SBDI-C

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Note: All terms in *italics* are listed and defined in the Definitions section or within the certificate itself.
CDI-3AA

SCHEDULE OF BENEFITS

Effective as of: January 1, 2015

Employer:	The Johns Hopkins University
Policy Number:	371107 (83148115)
Policy Effective Date:	July 1, 2003
Class 1 Eligibility:	All full-time Faculty and Senior Staff employees who are Actively at Work for the Employer and who have completed the waiting period required by the Employer. A full-time employee is one who regularly works a minimum of 28 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible. Bargaining Unit employees, Interns, Residents, Post-doctorial Fellows, employees of the Applied Physics Laboratory, and Johns Hopkins Emergency Medical Services are not eligible under Class 1.
Class 2 Eligibility:	All full-time Support Staff and Bargaining Unit, Local 1231 Amalgamated Municipal Laborers International Union AFL-CIO employees who are Actively at Work for the Employer and who have completed the waiting period required by the Employer. A full-time employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible. Interns, Residents, Post-doctorial Fellows, and employees of the Applied Physics Laboratory, and Johns Hopkins Emergency Medical Services are not eligible under Class 1.
Waiting Period:	If *You* are in a class eligible for insurance on or before the Policy Effective Date: No Waiting Period If *You* enter a class eligible for insurance after the Policy Effective Date: Date of hire.
Elimination Period:	14 Days – *Injury* 14 Days – *Sickness*
STD Weekly Benefit:	60% of *Weekly Earnings* to a maximum benefit of $1,000 per week subject to reduction by deductible sources of income or *Disability Earnings*.
Employer Contribution:	0% of premium
Maximum Period Payable:	11 weeks following the elimination period.
Reinstatement:	If, after termination of an employee's coverage because of termination of employment, the employee is rehired within 12 months after the date of termination and is eligible as stated in the Eligiblity provision, the employee's coverage may be reinstated. The request for reinstatement and payment of premium must be made within 31 days after becoming eligible again. Coverage will be reinstated and become effective on the date *Your* reinstatement is accepted by the Employer or *Us,* provided *You* are *Actively-at-Work*. If *You* are not *Actively-at-Work* on that date, the effective date of the reinstatement will be the date *You* return to *Active Work*.

If the request for reinstatement and payment of premium is not made within 31 days after the employee resumes eligibility, reinstatement will be subject to *Our* approval of the employee's *Evidence of Insurability*. *We* will notify the employee of the date of reinstatement.

OTHER FEATURES

The following other features are included:

- Work Incentive Benefit
- Minimum Benefit
- Recurrent Disability
- FMLA Coverage Extension
- Continuity of Coverage

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO *YOU* UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF *YOUR* CERTIFICATE.
SOBC

ELIGIBILITY AND EFFECTIVE DATES

Class 1

Are You eligible for this insurance?

All full-time Faculty and Senior Staff employees who are Actively at Work for the Employer and who have completed the waiting period required by the Employer.

A full-time employee is one who regularly works a minimum of 28 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible. Bargaining Unit employees, Residents, Inters, Post-doctorial Fellows, employees of the Applied Physics Laboratory, and Johns Hopkins Emergency Medical Services are not eligible under Class 1.

The waiting period is stated in the *Schedule of Benefits.*
CDI-4AA

Class 2

Are You eligible for this insurance?

All full-time Support Staff and Bargaining Unit, Local 1231 Amalgamated Municipal Laborers International Union AFL-CIO employees who are Actively at Work for the Employer and who have completed the waiting period required by the Employer.

A full-time employee is one who regularly works a minimum of 30 hours per week for the Employer. Part-time, seasonal and temporary employees are not eligible. Residents, Inters, Post-doctorial Fellows and employees of the Applied Physics Laboratory, and Johns Hopkins Emergency Medical Services are not eligible under Class 2.

The waiting period is stated in the *Schedule of Benefits.*
CDI-4AA

When does Your insurance become effective?

If *You* enroll on or before the Policy Effective Date, *Your* insurance shall take effect on such Date. If *You* enroll after the Policy Effective Date but within 31 days of becoming eligible, *Your* insurance will take effect on the date *Your* signed enrollment form is received by *Your* Employer.

If *You* enroll more than 31 days after becoming eligible, *Your* insurance will take effect after *We* approve such Evidence of Insurability as *We* require. *You* will be notified of *Your* effective date.

If, because of *Injury* or *Sickness*, *You* are eligible but not *Actively at Work* on the date the insurance would otherwise take effect, it will take effect on the day after *You* return to *Active Work* for a continuous period equal to the time *You* were not *Actively Working*. This return to *Active Work* requirement will not exceed 30 days.
CDI-5AA

Evidence of Insurability

If *You* are required to submit Evidence of Insurability, *You* must:

1) Complete and sign a health and medical history form provided by *Us;*
2) Submit to a medical examination, if requested;
3) Submit verification of *Weekly Earnings*;
4) Provide any additional information and attending physicians' statements that *We* require; and
5) Furnish all such evidence at *Your* own expense.

CDI-47AA

Who pays for Your coverage?

You pay the entire cost of *Your* coverage.
CDI-6AA

What happens if We are replacing an existing contract?

Effect on *Actively at Work* Provision

If *You* were insured under the Prior Policy on the day before the Policy Effective Date, *You* may be covered by the Policy even if *You* fail to satisfy the *Actively at Work* requirement as stated in the *Are You eligible for this insurance?* provision. *You* will receive credit for time covered under the Prior Policy. This credit will be applied toward satisfaction of service waiting periods, *Elimination Period*s or any other periods of the same or similar provisions under the Policy.

Effect on Benefits

If *You* do not satisfy the *Actively at Work* requirement, *You* may still be eligible for benefits under the Policy as follows:

The benefits payable under the Policy will be the benefit which would have been payable under the terms of the Prior Policy if it had remained in force. The benefits payable under the Policy will be reduced by any benefits paid under the Prior Policy for the same *Disability*.

Benefits will end on the earliest of the following:

1) the date that benefits would terminate in accordance with the provisions of the Policy; or
2) the date that benefits would terminate under the Prior Policy if it had remained in force.

The Prior Policy is the group disability insurance policy issued to the Employer by Unum Life Insurance Company of America whose coverage terminated as of the Policy Effective Date.
CDI-7AB

SHORT TERM DISABILITY BENEFITS

How do We define Disability?

Disability or *Disabled* means that *You* satisfy the Occupation Qualifier or the Earnings Qualifier as defined below.
CDI-9AA

Occupation Qualifier

Disability means that *Injury* or *Sickness* causes physical or mental impairment to such a degree of severity that *You* are:

1) continuously unable to perform the *Material and Substantial Duties* of *Your Regular Occupation*; and
2) not *Gainfully Employed*.

CDI-10CB

Earnings Qualifier

You may be considered *Disabled* during and after the *Elimination Period* in any week in which *You* are *Gainfully Employed*, if an *Injury* or *Sickness* is causing physical or mental impairment to such a degree of severity that *You* are unable to earn more than 80% of *Your Weekly Earnings* in any occupation for which *You* are qualified by education, training or experience.

You are not considered to be *Disabled* if *You* are able to earn more than 80% of *Your Weekly Earnings*. Salary, wages, partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive will be included. Sick pay and salary continuance payments will not be included. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDI-13AB

Loss of Professional License or Certification

If *You* require a professional license or certification for *Your* occupation, loss of that professional license or certification does not in and of itself constitute *Disability* under the Occupation Qualifier or the Earnings Qualifier.
CDI-14AA

What is the Elimination Period and how is it satisfied?

The *Elimination Period* begins on the day *You* become *Disabled*. It is a period of continuous *Disability* which must be satisfied before *You* are eligible to receive benefits from *Us*. *You* must be continuously *Disabled* through *Your Elimination Period*.

Can You satisfy Your Elimination Period if You are working?

You can satisfy *Your Elimination Period* if *You* are working, provided *You* meet the definition of *Disability*.
CDI-15BA

What Disability Benefit are You eligible to receive?

If *You* are *Disabled*, *You* are eligible to receive one of the following at any given time:

1) an STD Weekly Benefit; or
2) a Work Incentive Benefit.

While *You* are *Disabled*, *You* might be eligible to receive one or the other of the above, but *You* cannot receive more than one of these benefits at the same time.
CDI-16AA

What is Your STD Benefit and how is it calculated?

Your STD Weekly Benefit will be based on *Your Weekly Earnings* as reported to *Us* by *Your* Employer and for which premium has been paid.

An *STD Weekly Benefit* will be provided after the end of the *Elimination Period* if *You* are *Disabled* according to the Occupation Qualifier provision.

We will calculate *Your Gross STD Weekly Benefit* amount as follows:

1) Multiply *Your Weekly Earnings* by 60%.
2) The maximum *Gross STD Weekly Benefit* is $1,000.
3) Compare the answers from Item 1 and Item 2. The lesser of these two amounts is *Your Gross STD Weekly Benefit*.
4) Subtract the Deductible Sources of Income from *Your Gross STD Weekly Benefit*. The resulting figure is *Your Net STD Weekly Benefit*.

If a benefit is payable for less than one week, it will be prorated for each day of *Disability*.
CDI-17AB

How do We *define Earnings?*

Weekly Earnings equals the weekly wage or salary that *You w*ere receiving from *Your* Employer on the *Date of Disability*. It includes:

1) employee contributions made through a salary reduction agreement with *Your* Employer to an IRS Section 401(k), 403(b), 501(c)(3), 457 deferred compensation plan, or any other qualified or non-qualified employee *Retirement Plan* or deferred compensation arrangement; and
2) amounts contributed to *Your* fringe benefits according to a salary reduction arrangement under an IRS Section 125 plan.

It does not include:

1) commissions;
2) bonuses;
3) overtime pay;
4) *Your* Employer's contribution on *Your* behalf to a *Retirement Plan* or deferred compensation arrangement; or any other extra compensation.

CDI-19AA

What are the Deductible Sources of Income?

The *Gross Weekly Benefit* under this policy shall be reduced by *Disability* benefits paid, payable, or for which there is a right under:

1) Any Workers' Compensation or Occupational Disease Act or Law, or any other law which provides compensation for an occupational *Injury* or *Sickness*;
2) Occupational accident coverage provided by or through the Employer;
3) Any sick leave* or salary continuance* plan provided by or through the Employer;
4) Any Statutory Disability Benefit Law.

*Sick leave and/or salary continuance is only integrated when the sum of the sick leave and/or salary continuance exceeds 100% of the pre-disability earnings.

CDI-20AB

What other sources of income are not deductible?

We will not reduce *Your Gross STD Weekly Benefit* by any of the following:

1) deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
2) credit *Disability* insurance;
3) pension plans for partners;
4) military pension and *Disability* income plans;
5) franchise *Disability* income plans;
6) individual *Disability* income plans;
7) a *Retirement Plan* from another Employer;
8) profit sharing plans;
9) thrift or savings plans;
10) individual retirement account (IRA);
11) tax sheltered annuity (TSA);
12) stock ownership plan;
13) any No Fault Auto Motor Vehicle coverage.

CDI-21AB19

Can You work and still receive benefits?

While *Disabled, You* may qualify for the Work Incentive Benefit.
CDI-22AA

Work Incentive Benefit

A Work Incentive Benefit will be provided if *You* are *Disabled* and *Gainfully Employed* after the end of the *Elimination Period,* or after a period during which *You* received *STD Weekly Benefits*.

The Work Incentive Benefit will be equal to the *Net STD Weekly Benefit* amount less that amount of *Your Disability Earnings* which, when combined with *Your Net STD Weekly Benefit*, exceeds 100% of *Your Weekly Earnings* prior to *Disability*.

The Work Incentive Benefit will cease on the earliest of the following:

1) the date *You* are no longer *Disabled;* or
2) the end of the *Maximum Period Payable*.

CDI-23BB

What is the minimum Net STD Weekly Benefit payable under this program?

The *Net STD Weekly Benefit* payable for *Disability* will not be less than $25. The minimum *Net STD Weekly Benefit* does not apply if *You* are *Gainfully Employed.*
CDI-25AB

How long will You receive benefits under this program?

We will send *You* a payment for each week of *Disability* for the *Maximum Period Payable* as shown in the *Schedule of Benefits.* Payment of benefits is also subject to any benefit duration limitation pertaining to *Your Disability*.
CDI-27AB

What happens if Your Disability recurs?

If *Disability* for which benefits were payable ends but recurs due to the same or related causes less than or on the 14th day after the end of a prior *Disability*, it will be considered a resumption of the prior *Disability* and will not be subject to a new *Elimination Period* or a new *Maximum Period Payable*. Such recurrent *Disability* shall be subject to the provisions of the Policy that were in effect at the time the prior *Disability* began.

Disability which recurs after the 14th day of the end of a prior *Disability* are subject to:

1) a new *Elimination Period*;
2) a new *Maximum Period Payable*; and
3) the other provisions of the Policy that are in effect on the date the Disability recurs.

Disability must recur while *Your* coverage is in force under the Policy.
CDI-28AA19

EXCLUSIONS AND LIMITATIONS

What are the exclusions and limitations under this program?

The Policy does not cover any loss or *Disability* caused by, contributed to, or resulting from:
CDIX-1AA19

- attempted suicide, while sane or insane, or intentional self-inflicted *Injury* or *Sickness*;

CDIX-5AA

- *Your* commission of or attempt to commit an act which is a felony in the jurisdiction in which the act occurred;

CDIX-6AA19

- Occupational *Injury* or *Sickness*;

CDIX-10AA

Benefits are not payable for any period during which *You* are confined to a penal or correctional institution if the period of confinement exceeds 30 days.
CDIX-12AA

TERMINATION OF COVERAGE

When will Your insurance terminate?

Your coverage will terminate on the earliest of the following dates:

1) the date on which the Policy is terminated;
2) subject to the Grace Period, the date at the end of the period for which premium has been paid if the Employer fails to pay the required premium for *You* within 31 days after the premium due date, except for an inadvertent error; or
3) If *You* cease work due to a leave of absence or military leave, either paid or unpaid, coverage will continue for 3 months from the date *You* last actively worked, subject to continued payment of premium.
4) the premium due date which falls on or immediately follows the date *You*:
    a) are no longer a member of a class eligible for this insurance,
    b) withdraw from the program,
    c) are retired or pensioned, or
    d) cease work because of a furlough, layoff, or temporary work stoppage due to a labor dispute.

Termination will not affect a covered loss which began before the date of termination.
CDI-30AB19

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and *Your* Employer approves a leave under the Family and Medical Leave Act of 1993 (FMLA), *Your* insurance will continue for a period of up to 12 weeks following the date the leave begins, provided the required premium continues to be paid.

You are eligible for leave under this Act in order to provide care:

1) After the birth of a child; or
2) After the legal adoption of a child; or
3) After the placement of a foster child in *Your* home; or
4) To a *Spouse*, child or parent due to their serious illness; or
5) For *Your* own serious health condition.

While granted a Family or Medical Leave of Absence:

1) The Employer must remit the required premium according to the terms of the policy; and
2) Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* agreement with the Employer.

CDI-31AB

FILING A CLAIM

What are the Claim Filing Requirements?

Initial Notice of Claim

We ask that *You* notify *Us* of *Your* claim as soon as possible, so that *We* may make a timely decision on *Your* claim. The Employer can assist *You* with the appropriate telephone number and address of *Our* Claim Department. *You* must send *Us* written notice of *Your Disability* within 30 days of the *Date of Disability*, or as soon as reasonably possible. Notice may be sent to *Our* Claim Department, The Hartford, P.O. Box 14306, Lexington, KY 40512-4306.

Claim Forms

Within 15 days of *Our* being notified in writing of *Your* claim, *We* will supply *You* with the necessary claim forms. The claim form is to be completed and signed by *You*, the Employer and *Your Doctor*. If *You* do not receive the appropriate claim forms within 15 days, then *You* will be considered to have met the requirements for written proof of loss if *We* receive written proof, which describes the occurrence, extent and nature of loss as stated in the Proof of *Disability* provision.

Time Limit for Filing *Your* Claim

The time limit for filing claim forms is 90 days after the end of the *Elimination Period* for loss due to *Disability* and 90 days after the date of loss for any other loss covered by the Policy. The length of the *Elimination Period* is stated in the *Schedule of Benefits*. If it is not possible to give *Us* written proof within 90 days, the claim is not affected if the proof is given as soon as possible. How*e*ver, unless *You* are legally incapacitated, written proof of loss must be given no later than 1 year after the time proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time proof is due. How*e*ver, *You* can request that benefits be paid for late claims if *You* can show that:

1) It was not reasonably possible to give written proof during the 1 year period; and
2) Proof of loss satisfactory to *Us* was given as soon as was reasonably possible.

Proof of *Disability*

The following items, supplied at *Your* expense, must be a part of *Your* proof of loss. Failure to do so may delay, suspend or terminate *Your* benefits.

1) The date *Your Disability* began;
2) The cause of *Your Disability*;
3) The prognosis of *Your Disability*;
4) Proof that *You* are receiving *Appropriate and Regular Care* for *Your* condition from a *Doctor*, who is someone other than *You* or a member of *Your* immediate family, whose specialty or expertise is the most appropriate for *Your* disabling condition(s) according to *Generally Accepted Medical Practice*.
5) Objective medical findings which support *Your Disability*. Objective medical findings include but are not limited to tests, procedures, or clinical examinations standardly accepted in the practice of medicine, for *Your* disabling condition(s).
6) The extent of *Your Disability*, including restrictions and limitations which are preventing *You* from performing *Your Regular Occupation*.
7) Appropriate documentation of *Your Weekly Earnings*. If applicable, regular monthly documentation of *Your Disability Earnings*.
8) If *You* were contributing to the premium cost, *Your* Employer must supply proof of *Your* appropriate payroll deductions.
9) The name and address of any *Hospital* or *Health Care Facility* where *You* have been treated for *Your Disability*.
10) If applicable, proof of incurred costs covered under other benefits included in the Policy.

Continuing Proof of *Disability*

You may be asked to submit proof that *You* continue to be *Disabled* and are continuing to receive *Appropriate and Regular Care* of a *Doctor*. Requests of this nature will only be as often as *We* feel reasonably necessary. If so, this will be at *Your* expense and must be received within 30 days of *Our* request. However, failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of *Your* legal capacity, not later than 1 year from the time proof is otherwise required.

Examination

At *Our* expense, *We* have the right to have *You* examined as often as reasonably necessary while the claim continues. Failure to comply with this examination may deny, suspend or terminate benefits, unless *We* agree *You* have a valid and acceptable reason for not complying.

Authorization and Documentation *You* will be asked to supply

1) *You* will be required to provide signed authorization for *Us* to obtain and release all reasonably necessary medical, financial or other non-medical information which support *Your Disability* claim. Failure to submit this information may deny, suspend or terminate *Your* benefits.
2) *You* will be required to supply proof that *You* have applied for other Deductible Income Benefits such as Workers' Compensation or Social Security *Disability* benefits, when applicable.
3) *You* will be required to notify *Us* when *You* receive or are awarded other Deductible Income Benefits. *You* must tell *Us* the nature of the income benefit, the amount received, the period to which the benefit applies, and the duration of the benefit if it is being paid in installments.

CDI-36AB19

Time of Payment of Claim

As soon as *We* have all necessary substantiating documentation for *Your Disability* claim, *Your* benefit will be paid on a weekly basis, so long as *You* continue to qualify for it.

We will pay benefits to *You* unless otherwise indicated. If *You* die while *Your* claim is open, any due and unpaid *Disability* benefit will be paid to *Your* named beneficiary, if any.

If there is no surviving beneficiary, payment may be made to the surviving person or persons in the first of the following classes of successive preference beneficiaries: *Your:* 1) spouse; 2) children including legally adopted children; 3) parents; 4) brothers or sisters; or 5) estate.

If any benefit is payable to an estate, a minor or a person not competent to give a valid release, *We* may pay up to $1,000 to any relative or beneficiary of *Yours* whom *We* deem to be entitled to this amount. *We* will be discharged to the extent of such payment made by *Us* in good faith.
CDI-37AB19

Can you assign Your benefits?

Your benefits are not assignable, which means that *You* may not transfer *Your* benefits to anyone else.
CDI-38AA

What will happen if a claim is overpaid?

A claim overpayment can occur when *You* receive a retroactive payment from a Deductible Source of Income; when *We* inadvertently make an error in the calculation of *Your* claim; or if fraud occurs.

In an overpayment situation, *We* will determine the method by which the repayment is made. *You* will be required to sign an agreement with *Us* which details the source of the overpayment, the total amount *We* will recover and the method of recovery.

The overpayment amount equals the amount *We* paid in excess of the amount *We* should have paid under the Policy.
CDI-39AA

Subrogation – Right of Reimbursement

When any claim payment is made, *We* reserve any and all rights to subrogation and/or reimbursement to the fullest extent allowed by statute and customary practice. Any party to this contract shall not perform any act that will prejudice such rights without prior agreement with *Us*.

We will bear any expenses associated with *Our* pursuit of subrogation or recovery.
CDI-41AA

Fraud

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and may subject such person to criminal and civil penalties. Such penalties include, but are not limited to fines, denial or termination of insurance benefits, recovery of any amounts paid, civil damages, criminal prosecution and confinement in state prison.
CDI-42AA

UNIFORM PROVISIONS

Entire Contract; Changes

The Policy, the Employer's application, the employee's certificate of coverage, and *Your* application, if any, and any other attached papers, form the entire contract bet*we*en the parties. Coverage under the Policy can be amended by mutual consent betw*e*en the Employer and *Us*. No change in the Policy is valid unless approved in writing by one of *Our* officers. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

Any statement made by the Employer or *You*, except for fraudulent misstatements, is considered a representation and not a warranty. No statement used to effect the Policy or coverage under the Policy, will be used to void the Policy or reduce benefits unless the statement is contained in a written instrument signed by, and a copy provided to the Employer or *You*, whoever made the statement. No statement of the Employer will be used to void the Policy after it has been in force for 2 years. No statement of *Yours* will be used in defense of a claim after *You* have been insured for 2 years, except for fraudulent misstatements.

Change of Beneficiary

You have the right to change a beneficiary or beneficiaries and the consent of the beneficiary or beneficiaries is not required for such a change.

Legal Actions

No legal action of any kind may be filed against *Us* :

1) within the 60 days after proof of *Disability* has been given; or
2) more than 3 years after proof of *Disability* must be filed, unless the law in the state where *You* live allows a longer period of time.

Conformity with State Statutes

If any provision of the Policy conflicts with the statutes of the state in which the Policy was issued or delivered, it is automatically changed to meet the minimum requirements of the statute.
CDI-40AB19

General Provisions

We have the right to inspect all of the Employer's records on the Policy at any reasonable time. This right will extend until:

1) 2 years after termination of the Policy; or
2) all claims under the Policy have been settled,

whichever is later.

The Policy is in the Employer's possession and may be inspected by *You* at any time during normal business hours at the Employer's office.

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation Insurance.
CDI-43AB

DEFINITIONS

The following are key words and phrases used in this certificate. When these words and phrases, or forms of them, are used, they are capitalized and italicized in the text. As *You* read this certificate, refer back to these definitions.

Actively at Work or ***Active Work*** means *You*:

1) must be working at the Employer's usual place of business, or on assignment for the purpose of furthering the Employer's business; and
2) must be performing the *Material and Substantial Duties* of *Your Regular Occupation* on a full-time basis and
3) must not be *Injured*, *Sick* or otherwise *Disabled* or, if absent from work while not *Disabled*, *You* were *Actively at Work* or in *Active Work* on the last work day before the day of absence.

CDID-1AB19

Appropriate and Regular Care means that *You* are regularly visiting a *Doctor* as frequently as medically required to meet *Your* basic health needs. The effect of the care should be of demonstrable medical value for *Your* disabling condition(s) to effectively attain and/or maintain *Maximum Medical Improvement*.
CDID-4AA

Date of Disability is the date *We* determine *Your Injury* or *Sickness* impairs *Your* ability to perform *Your Regular Occupation.*
CDID-5AA

Disability or ***Disabled*** means that *You* satisfy either the Occupation Qualifier or the Earnings Qualifier.
CDID-6AA

Disability Earnings is the wage or salary *You* earn from *Gainful Employment* after a *Disability* begins. It includes partnership or proprietorship draw, commissions, bonuses, or similar pay, and any other income *You* receive or are entitled to receive. It does not include Social Security, sick pay, salary continuance payments or any other *Disability* payment *You* receive as a result of *Your Disability*. Any lump sum payment will be prorated, based on the time over which it accrued or the period for which it was paid.
CDID-7AB

Doctor means a person legally licensed to practice medicine, psychiatry, psychology or psychotherapy, who is neither *You* nor a member of *Your Immediate Family*. A licensed medical practitioner is a *Doctor* if applicable state law requires that such practitioners be recognized for purposes of certification of *Disability*, and the treatment provided by the practitioner is within the scope of his or her license.
CDID-8AA

Elimination Period means the number of calendar days at the beginning of a continuous period of *Disability* for which no benefits are payable. The *Elimination Period* is shown in the *Schedule of Benefits*.
CDID-9AA

Gainful Employment or ***Gainfully Employed*** means the performance of any occupation for wages, remuneration or profit, for which *You* are qualified by education, training or experience on a full-time or part-time basis, and which *We* approve and for which *We* reserve the right to modify approval in the future.
CDID-10AB

Generally Accepted Medical Practice or ***Generally Accepted in the Practice of Medicine*** means care and treatment which is consistent with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies.
CDID-11AA

Gross STD Weekly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AGross

Hospital or Health Care Facility is a legally operated, accredited facility licensed to provide full-time care and treatment for the condition(s) causing *Your Disability*. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities which primarily provide custodial, educational or rehabilitative care.
CDID-12AA

Immediate Family means *Your* spouse, children, parents, sisters, brothers, cousins or in-laws.
CDID-31AA19

Injury means bodily injury caused by an accident which results, directly and independently of all other causes, in *Disability* which begins while *Your* coverage is in force.
CDID-13AA

Male pronoun, whenever used, includes the female.
CDID-16AA

Material and Substantial Duties means the necessary functions of *Your Regular Occupation* which cannot be reasonably omitted or altered.
CDID-17AA

Maximum Medical Improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an *Injury* or *Sickness* can no longer be reasonably anticipated.
CDID-18AA

Maximum Period Payable, as shown in the *Schedule of Benefits*, means the longest period of time that *We* will make payments to *You* for any one period of *Disability*.
CDID-32AA

Net STD Weekly Benefit means the *Gross Short Term Disability Weekly Benefit* less the Deductible Sources of Income.
CDID-20ANet

Regular Occupation means the occupation that *You* are performing for income or wages on *Your Date of Disability*. It is not limited to the specific position *You* held with *Your* Employer.
CDID-22BA

Retirement Plan means a plan which provides retirement benefits to employees and is not funded wholly by employee contributions.
CDID-24AA

Schedule of Benefits means the schedule which is a part of this certificate.
CDID-28AA

STD means Short Term *Disability*.
CDID-34AA

Sickness means sickness or disease causing *Disability* which begins while *Your* coverage is in force.
CDID-26AA

We, ***Our*** and ***Us*** mean the Hartford Life and Accident Insurance Company.
CDID-29AA

Weekly Benefit means that benefit shown in the *Schedule of Benefits* which applies to *You*.
CDID-20AA

You, ***Your*** and ***Yours*** means the employee to whom this certificate is issued and whose insurance is in force under the terms of the Policy.
CDID-30AA

IMPORTANT ERISA WELFARE PLAN INFORMATION

The following section contains information provided to You at the request of the Plan Administrator of Your Plan to meet certain requirements of the Employee Retirement Income Security Act of 1974, as amended, (ERISA). All inquiries related to the following material should be referred directly to Your Plan Administrator.

DISCRETIONARY AUTHORITY

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto. The plan administrator and other plan fiduciaries have discretionary authority to determine Your eligibility for and entitlement to benefits under the Policy. The plan administrator has delegated sole discretionary authority to Hartford Life and Accident Insurance Company to determine Your eligibility for benefits and to interpret the terms and provisions of the plan and any policy issued in connection with it.

SUMMARY PLAN DESCRIPTION (SPD) AND ERISA STATEMENT OF RIGHTS

The following sections contain information provided to You by the Plan Administrator of Your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended. It does not constitute a part of the Plan, nor of any insurance policy issued in connection with it. All inquiries relating to the following material should be referred directly to Your Plan Administrator.

SUMMARY PLAN DESCRIPTION

Name of Plan

The plan for which this Summary Plan Description is provided is known as the The Johns Hopkins University Group Disability Income Insurance Plan, herein referred to as the "Plan".

Maintenance of Plan

The Plan is maintained by:

The Johns Hopkins University
Johns Hopkins at Eastern
Suite D100, 1101 E. 33rd Street
Baltimore, MD 21218

Employer Identification Number and Plan Number

The employer identification number (EIN) assigned by the Internal Revenue Service to the Plan Sponsor is 52-0595110.

The Plan Number assigned by the Plan sponsor is 512.

Type of Welfare Plan

The Plan is a group disability income insurance plan.

Administration of Plan

The Plan is administered by the Plan Administrator through an insurance contract purchased from Hartford Life and Accident Insurance Company. Certain ministerial functions are performed on behalf of the Plan by Hartford Life and Accident Insurance Company. These functions include, but are not limited to, administration and payment of claims, determination of Your eligibility under the Plan, premium billing and policy and certificate issuance.

Plan Sponsor/Administrator (Herein referred to as the Administrator)

The Johns Hopkins University
Johns Hopkins at Eastern
Suite D100, 1101 E. 33rd Street
Baltimore, MD 21218
Telephone Number: 443-997-5800

The Administrator and other Plan fiduciaries have discretionary authority to interpret the terms of the Plan and to determine Your eligibility for and entitlement to benefits in accordance with the Plan. With respect to making benefit decisions, the Plan Administrator has delegated sole discretionary authority to Hartford Life and Accident Insurance Company to determine Your eligibility for and entitlement to benefits under the Plan and to interpret the terms and provisions of any insurance policy issued in connection with the Plan.

Agent for Service of Legal Process

The person designated as agent for service of legal process upon the Plan is:

The Johns Hopkins University
Johns Hopkins at Eastern
Suite D100, 1101 E. 33rd Street
Baltimore, MD 21218

In addition, service of process may be made upon the Administrator.

Eligibility and Benefits

The Plan's requirements respecting eligibility for participation, the conditions pertaining to eligibility to receive benefits and a description or summary of the benefits are listed in the certificate portion of this booklet.

Circumstances Which May Affect Benefits

Circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are listed in the certificate portion of this booklet.

The Plan Administrator reserves the right to modify, amend, or terminate the Plan in whole or in part. Such right may be exercised at any time and at the Plan Administrator's sole discretion.

Right of Recovery Due to Benefit Overpayment

If, for any reason, a benefit is paid under the Plan which is larger than the amount allowed in accordance with the Plan, the Plan reserves the right to recover the excess amount from the person or agency that received such overpayment.

Sources of Plan Contributions

Contributions to the Plan are made by the employer.

Medium for Providing Benefits

Benefits under the Plan are provided in accordance with the provisions of Group Insurance Policy Number 83148115 by Hartford Life and Accident Insurance Company. Benefits available under the Plan are not guaranteed under the Group Insurance Policy.

Date of End of Plan's Fiscal Year

The date of the end of each year for purposes of maintaining the Plan's fiscal records is June 30.

Claim Procedures

1) **Presenting Claims for Benefits**

Claim forms may be obtained from: Employer.

Please see Your insurance certificate or booklet for the requirements of the Group Insurance Policy as to notice of claims.

The insurance company will provide notice of benefit determination no later than 45 days after receipt of the claim. This period may be extended by 30 days if it is determined that matters beyond the control of the plan make such an extension necessary. You will receive written notification of the extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 45-day period. If, prior to the end of the 30-day extension period, it is determined that a decision cannot be made due to matters beyond the control of the plan, the period for making the decision may be extended for up to an additional 30 days. You will be notified in writing of the additional extension and the date by which the insurance company expects to decide your claim prior to the end of the initial 30-day extension period. Each notice of extension will explain the standards on which entitlement to benefits is based, the reasons for the delay, and the additional information needed to make a decision on the claim. If the extension is due to your failure to submit information necessary to decide the claim, the time limitations for the insurance company will be tolled from the date the notification of the extension is sent until the date you respond to the request for additional information. You will have 45 days within which to provide the necessary information.

2) **Claims Denial Procedure**

Any denial of a claim for benefits will be provided by the insurance company and consist of a written explanation which will include:

i) the specific reasons for the denial;
ii) reference to the pertinent plan provisions upon which the denial is based;
iii) a description of any additional information You might be required to provide and explanation of why it is needed; and
iv) an explanation of the Plan's claim review procedure.

You, Your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to the insurance company. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 180 days after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by the insurance company no longer than 45 days after receipt of the request for the review.

If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receipt of the request for the review. If such an extension of time is needed, You will be notified in writing prior to the beginning of the time extension period. The decision after Your review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

ERISA AND EFFECT ON EMPLOYMENT

No one may fire You or otherwise discriminate against You in order to prevent You from obtaining a welfare benefit You are entitled to under the Plan or exercising Your rights under ERISA. However, nothing listed herein, or in any Plan document or insurance policy issued in connection with the Plan, shall be construed to say or imply that Your participation in the Plan is a guarantee of Your continued employment with Your employer. Your employment status shall not be affected by Your participation in the Plan or exercise of Your rights under ERISA.

YOUR RIGHTS UNDER ERISA

As a participant in the above described Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following rights and protections under the law.

Receive Information About Your Plan and Benefits

As a participant in an ERISA covered Plan, You have the right to:

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in 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.

Assistance with Your Questions

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

IMPORTANT NOTICE FOR NON-ENGLISH SPEAKING EMPLOYEES

Para Empleados Que No Hablan Inglés

Este documento contiene un resumen en inglés de los derechos y beneficios que le corresponden bajo el plan de seguro de incapacidades grupal creado y mantenido por su empresa. Si tiene alguna pregunta acerca de la información contenida en el documento, communiquese con el Administrador para obtener ayuda. La dirección del Administrador es:

The Johns Hopkins University
Johns Hopkins at Eastern
Suite D100, 1101 E. 33rd Street
Baltimore, MD 21218
Numero de Teléfono: 443-997-5800

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $300,000 in health insurance benefits, including net cash surrenders and net cash withdrawal values
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, are the amounts listed above.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation

9199 Reisterstown Road

P.O. Box 671—Suite 216C

Owings Mills, Maryland.21117

410-998-3907

Maryland Insurance Administration

200 St. Paul Place, Suite 2700

Baltimore, Maryland.21202

1-800-492-6116, ext. 2170

I**nsurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.**

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company.