
**GROUP
BENEFIT
PLAN**

MUHLENBERG COLLEGE

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Group Long Term Disability Benefits

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

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

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

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

- are eligible for the insurance;
 - become insured; and
 - continue to be insured;
- according to the terms of the Policy.

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

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

Richard G. Costello, *Secretary*

Thomas M. Marra, *President*

SCHEDULE OF INSURANCE

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

Policyholder: MUHLENBERG COLLEGE
Group Insurance Policy: GLT-674197
Plan Effective Date: November 1, 2001

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

Must you contribute toward the cost of coverage?

You do not contribute toward the cost of coverage.

Who is eligible for coverage?

Eligible Class(es): All Active Full-time Employees who are U.S. citizens or U.S. residents, excluding temporary and seasonal employees

Full-time Employees: 24 hours weekly or a minimum of 1,248 hours per year

Maximum Monthly Benefit: \$5,000

The **Minimum Monthly Benefit** will be the greater of:

- \$100; or
- 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

Benefit Percentage: 66 2/3%

When will You become eligible? (Eligibility Waiting Period)

You will be eligible for coverage on the date on which You complete a waiting period of 365 days of continuous service.

The waiting period will be reduced by the period of time You were an Active Full-time Employee with the Employer under the Prior Plan.

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

1. the first 180 consecutive day(s) of any one period of Disability; or
2. with the exception of benefits required by state law, the expiration of any Employer sponsored short term disability benefits or salary continuation program.

MAXIMUM DURATION OF BENEFITS TABLE

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

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

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

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

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?

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

When will you become eligible?

You will become eligible for coverage on either:

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

See the Schedule of Insurance for the Eligibility Waiting Period.

How do you enroll?

Eligible Persons will be enrolled automatically by the Employer.

WHEN COVERAGE STARTS

When does your coverage start?

If you are not required to contribute toward the plan's cost, your coverage will start on the date you become eligible.

DEFERRED EFFECTIVE DATE

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

If you are absent from work due to:

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

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

CHANGES IN COVERAGE

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

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

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

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

No change in your Rate of Basic Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the plan?

Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, subject to the following limitations on an increase:

1. the Deferred Effective Date provision; and
2. Pre-existing Conditions Limitations.

BENEFITS

When do benefits become payable?

You will be paid a monthly benefit if:

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

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

When will benefit payments terminate?

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

1. the date you are no longer Disabled as defined;
2. the date you fail to furnish Proof of Loss, when requested by us;
3. the date you are no longer under the Regular Care of a Physician, or refuse our request that you submit to an examination by a Physician;
4. the date you die;
5. the date your Current Monthly Earnings exceed:
 - a) 80% of your Indexed Pre-disability Earnings if you are receiving benefits for being Disabled from Your Occupation;
 - b) an amount that is equal to the product of your Indexed Pre-disability Earnings and the Benefit Percentage if you are receiving benefits for being Disabled from Any Occupation;
6. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance;
7. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
8. the date you refuse to participate in a Rehabilitation program or, refuse to cooperate with or try:
 - a) modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the Essential Duties of Your Occupation;
 - b) adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the Essential Duties of Your Occupation;
 - c) modifications made to the work site or job process to accommodate your identified medical limitations to enable you to perform the Essential Duties of Any Occupation, if you were receiving benefits for being disabled from Any Occupation; or
 - d) adaptive equipment or devices designed to accommodate your identified medical limitations to enable you to perform the Essential Duties of Any Occupation, if you were receiving benefits for being disabled from Any Occupation,

provided a qualified Physician agrees that such modifications, Rehabilitation program or adaptive equipment accommodate your medical limitation; or

9. the date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS

Are benefits limited for Mental Illness or Substance Abuse?

If you are Disabled because of:

1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable:

1. only for so long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when you are not so confined, a total of 24 months for all such Disabilities during your lifetime.

RECURRENT DISABILITY

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

Attempts to return to work as an Active Full-time Employee during the Elimination Period will not interrupt the Elimination Period, provided no more than 30 such return-days are taken.

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

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

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

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

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

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

CALCULATION OF MONTHLY BENEFIT

How are Disability benefits calculated?

Return to Work Incentive

If you remain Disabled after the Elimination Period, but work while you are Disabled, we will determine your Monthly Benefit for a period of up to 12 consecutive months as follows:

1. multiply your Pre-Disability Earnings by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

Current Monthly Earnings will not be used to reduce your Monthly Benefit. However, if the sum of your Monthly Benefit and your Current Monthly Earnings exceeds 100% of your Pre-disability Earnings, we will reduce your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1. the day you first start such work; or
2. the end of the Elimination Period.

If you are Disabled and not receiving benefits under the Return to Work Incentive, we will calculate your Monthly Benefit as follows:

1. multiply your Monthly Income Loss by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

The result is your Monthly Benefit.

What happens if the sum of the Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of Pre-disability Earnings?

We will reduce your Monthly Benefit by the amount of the excess.

Minimum Monthly Benefit

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

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

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

Benefit Percentages and Maximum Benefits are shown in the Schedule of Insurance.

REHABILITATION

What is Rehabilitation?

Rehabilitation is a process of working together to plan, adapt, and put into use options and services to meet your return to work needs.

A Rehabilitation program may include, when we consider it to be appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
 - a) support groups;
 - b) physical therapy;
 - c) occupational therapy; and
 - d) speech therapy;
4. work-place modification to the extent not otherwise provided; and
5. job placement,

and similar services.

FAMILY CARE CREDIT BENEFIT

What if you must incur expenses for Family Care Services in order to participate in a Rehabilitative program?

If you are working as part of a program of Rehabilitative Employment, we will, for the purpose of calculating your benefit, deduct the cost of Family Care from earnings received from a Rehabilitative program, subject to the following limitations:

1. Family Care means the care or supervision of:
 - a) your children under age 13; or
 - b) a member of your household who is mentally or physically handicapped and dependent upon you for support and maintenance;
2. the maximum monthly deduction allowed for each qualifying child or family member is:
 - a) \$350 during the first 12 months of Rehabilitative Employment; and
 - b) \$175 thereafter,
 - c) but in no event may the deduction exceed the amount of your monthly earnings;
3. Family Care Credits may not exceed a total of \$2,500 during a calendar year;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
 - a) you are no longer in a Rehabilitative program; or
 - b) Family Care Credits for 24 months have been deducted during your Disability; and
7. no Family Care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Your Current Monthly Earnings after the deduction of your Family Care Credit will be used to determine your Monthly Income Loss. In no event will you be eligible to receive a Monthly Benefit under the plan if your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of your Indexed Pre-disability Earnings.

COST-OF-LIVING ADJUSTMENT

How do benefits keep abreast of inflation?

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

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

What is the Cost-of-Living Formula?

To apply the Cost-of-Living Formula:

1. determine the lesser of:
 - a) 3%; or
 - b) 1/2 the percentage change in the Consumer Price Index;
2. multiply the resulting percentage (%) times the Monthly Benefit for Disability being received; and
3. add the resulting amount to your Monthly Benefit.

How long will Cost-of-Living Adjustments continue?

No Cost-of-Living Adjustment will be made after you cease to be Disabled or you have received 10 adjustments.

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

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

"Totally Disabled," when used in this benefit, means that because of being Disabled, your Current Monthly Earnings are less than 20% of your Pre-disability Earnings.

SURVIVOR INCOME BENEFIT

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

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

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

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

The Benefit is one payment of an amount that is 6 times the lesser of:

1. your Monthly Income Loss multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.

The following terms apply to this Benefit:

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

PENSION CONTRIBUTION BENEFIT

Does this plan also cover contributions to a Pension Plan?

If you:

1. become Disabled while you are covered under this Pension Contribution Benefit;
2. remain Disabled for 365 days of one continuous period of Disability; and
3. are receiving a Monthly Benefit under this plan,

a Pension Contribution Benefit will be payable to the trustee or administrator of your Pension Plan for deposit to your pension account. The Pension Contribution Benefit amount will be as follows:

1. If Your date of hire is prior to January 1, 1973, 10% of the first \$541.67 of your Pre-disability Earnings, plus 15% of your Pre-disability Earnings which exceed \$541.67;
2. If Your date of hire is on or after January 1, 1973, 10% of that portion of your Pre-disability Earnings that are subject to Social Security (FICA) taxes, plus 15% of the balance of your Pre-disability Earnings.

The Pension Contribution Benefit will be subject to a maximum of \$1,250.00, regardless of the formula used above to calculate the benefit.

Payments under this benefit are made according to the rules and regulations of the Internal Revenue Service and the provisions of your Pension Plan. Any such payment that can not be paid to the trustee or administrator of your Pension Plan will be paid to a deferred annuity account designated by you.

How long will payments be made under this benefit?

No Pension Contribution Benefit will be payable after your Monthly Benefit for Disability ends for any reason.

Pension Plan means, for the purpose of this Pension Contribution Benefit, a qualified defined contribution pension plan, profit sharing plan, or other plan approved by us, in which you are participating as a result of your employment with the Employer.

PRE-EXISTING CONDITIONS LIMITATIONS

Are there any other limitations on coverage?

No benefit will be payable under the plan for any Disability that is due to, contributed to by, or results from a Pre-existing Condition, unless such Disability begins:

1. after the last day of 90 consecutive day(s) while insured during which you receive no medical care for the Pre-existing Condition; or
2. after the last day of 365 consecutive day(s) during which you have been continuously insured under this plan.

Pre-existing Condition means:

1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which you received Medical Care during the 90 day period that ends the day before:

1. your effective date of coverage; or
2. the effective date of a Change in Coverage.

Medical Care is received when:

1. a Physician is consulted or medical advice is given; or
2. treatment is recommended, prescribed by, or received from a Physician.

Treatment includes but is not limited to:

1. medical examinations, tests, attendance or observation; and
2. use of drugs, medicines, medical services, supplies or equipment.

CONTINUITY FROM A PRIOR PLAN

Is there continuity of coverage from a Prior Plan?

If you were:

1. insured under the Prior Plan;
2. Actively at Work; and
3. not eligible to receive benefits under the Prior Plan,

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply to you.

If you become insured under the Group Insurance Policy on the Plan Effective Date and were covered under the Prior Plan on the day before the Plan Effective Date, the Pre-existing Conditions Limitation will cease to apply on the first to occur of the following dates:

1. the Plan Effective Date, if your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Plan; or
2. if your coverage was limited by a pre-existing condition restriction under the Prior Plan, the date the restriction would have ceased to apply had the Prior Plan remained in force.

If you received Monthly Benefits for Disability under the Prior Plan, and:

1. you returned to work as an Active Full-time Employee before the Effective Date of this plan;
2. within 6 months of the return to work, you have a recurrence of the same Disability under this plan; and
3. there are no benefits available for the recurrence under the Prior Plan,

the Elimination Period of this plan, which would otherwise apply to the recurrence, will be waived if the recurrence would have been covered without any further Elimination Period under the Prior Plan had it remained in force.

EXCLUSIONS

What Disabilities are not covered?

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

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

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

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

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

TERMINATION

When does your coverage terminate?

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

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

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

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

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

Must premiums be paid during a Disability?

No premium will be due for you:

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

Do benefits continue if the plan terminates?

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

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

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

May coverage be continued during a family or medical leave?

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

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

GENERAL PROVISIONS

What happens if facts are misstated?

If material facts about you were not stated accurately:

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

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

When should we be notified of a claim?

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

Are special forms required to file a claim?

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

What is Proof of Loss?

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

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

All proof submitted must be satisfactory to us.

When must Proof of Loss be given?

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

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

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

When must one apply for Social Security Benefits?

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

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

What additional Proof of Loss are we entitled to?

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

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

Who gets the benefit payments?

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

When are payment checks issued?

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

What notification will you receive if your claim is denied?

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

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

What recourse do you have if your claim is denied?

On any claim, you or your representative may appeal to us for a full and fair review. You may:

1. request a review upon written application within 180 days of the claim denial;
2. request copies of all documents, records, and other information relevant to your claim; and
3. submit written comments, documents, records and other information relating to your claim.

We will make a decision no more than 45 days after we receive your appeal unless we determine special circumstances exist that require an extension of time to process the appeal. If your appeal requires extension, we will make our decision no more than 90 days after we receive your appeal. The written decision will include specific references to the Policy provisions on which the decision is based.

When can legal action be started?

Legal action cannot be taken against us:

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

What happens if benefits are overpaid?

An overpayment occurs when it is determined that the total amount we have paid in benefits is more than the amount that was due to you under the plan. This includes, but is not limited to, overpayments resulting from:

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

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

What are our subrogation rights?

If an Insured Person:

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

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

How do we deal with fraud?

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

Who interprets policy terms and conditions?

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

DEFINITIONS

The terms listed will have these meanings.

Actively at Work

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

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours indicated in the Schedule of Insurance.

Any Occupation means an occupation for which you are qualified by education, training or experience, and that has an earnings potential greater than an amount equal to the lesser of the product of your Indexed Pre-disability Earnings and the Benefit Percentage and the Maximum Monthly Benefit shown in the Schedule of Insurance.

Current Monthly Earnings means the monthly earnings you receive from:

1. the Employer while Disabled;
2. other employment.

However, if the other employment is a job you held in addition to Active Full-time Employment with the Employer, then:

1. during the Elimination Period, and while eligible to receive benefits for being Disabled from Your Occupation;
2. any earnings from this other employment will be Current Monthly Earnings only to the extent that such earnings exceed the average monthly earnings you were receiving from this other job during the 6 month period immediately prior to becoming Disabled.

Current Monthly Earnings will also include the amount of pay for another or modified job position, which may be offered to you by the Employer or other employer, if you refuse the offer. The requirements of such position must be within your capabilities as described by your Physician, and consistent with your education, training and experience.

Disability or Disabled means that during the Elimination Period and for the next 24 months you are prevented by:

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

from performing one or more of the Essential Duties of Your Occupation, and as a result your Current Monthly Earnings are no more than 80% of your Indexed Pre-disability Earnings.

After that, you must be so prevented from performing one or more of the Essential Duties of Any Occupation.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation does not alone mean that you are Disabled.

Employer means the Policyholder.

Essential Duty means a duty that:

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

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

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

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

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

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

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

Mental Illness means a neurosis, psychoneurosis, psychopathy, or psychosis including mental, nervous or emotional disorders without demonstrable organic origin.

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

Monthly Income Loss is the difference of your Pre-disability Earnings less your Current Monthly Earnings.

Monthly Rate of Basic Earnings means your regular monthly rate of pay from the Employer just prior to the date you become Disabled:

1. including contributions you make through a salary reduction agreement with the Employer to:
 - a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
 - b) an executive non qualified deferred compensation arrangement; or
 - c) a salary reduction arrangement under an IRC Section 125 plan; and
2. not including bonuses, commissions, overtime pay or expense reimbursements for the same period as above.

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

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
3. plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization;
4. disability benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act that you, your spouse and children are eligible to receive because of your Disability; or
5. disability benefit from the Veteran's Administration, or any other foreign or domestic governmental agency:
 - a) that begins after you become Disabled; or
 - b) if you were receiving the benefit before becoming Disabled, the amount of any increase in the benefit that is attributed to your Disability.

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

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

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

5. retirement benefits under:
 - a) the United States Social Security Act or alternative plan offered by a state or municipal government;
 - b) the Railroad Retirement Act;
 - c) the Canada Pension Plan, the Canada Old Age Security Act; the Quebec Pension Plan or any provincial pension or disability plan; or
 - d) similar plan or act that you, your spouse and children receive because of your retirement, unless you were receiving them prior to becoming Disabled.

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

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

We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim. Please see the provision entitled, What happens if benefits are overpaid?

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

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

Physician means a person who is:

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

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

Prior Plan means the long term disability insurance carried by the Employer on the day before the Plan Effective Date.

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

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

to achieve the maximum medical improvement.

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

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

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

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

Substance includes alcohol and drugs but excludes tobacco and caffeine.

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

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

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

ERISA

**The Following Important Notice
is Provided by Your Employer
for your Information Only.**

Conforming Instrument

For the purpose of meeting certain requirements of the Employee Retirement Income Security Act of 1974, the following information and the attached Claim Procedures and Statement of ERISA Rights are provided for use with your booklet-certificate to form the Summary Plan Description.

The benefits described in your booklet are provided under a group plan by the Insurance Company and are subject to the terms and conditions of that plan.

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

1. Plan Name

Group Long Term Disability Plan for employees of MUHLENBERG COLLEGE

2. Plan Number

502

3. Employer/Plan Sponsor

MUHLENBERG COLLEGE
2400 Chew Street
Allentown, PA 18104

4. Employer Identification Number

23-1352664

5. Type of Plan

Welfare Benefit Plan providing Group Long Term Disability.

6. Plan Administrator

MUHLENBERG COLLEGE
2400 Chew Street
Allentown, PA 18104

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

For the Plan:

MUHLENBERG COLLEGE
2400 Chew Street
Allentown, PA 18104

For the Policy:

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

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

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

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

10. The Plan and its records are kept on a Policy Year basis.
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11. **Labor Organizations**

None

12. **Names and Addresses of Trustees**

None

13. **Plan Amendment Procedure**

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

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

Statement of ERISA Rights

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:

1. Receive Information About Your Plan and Benefits:

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

2. Prudent Actions by Plan Fiduciaries:

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

3. Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions:

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Claim Procedures for Disability Income Insurance Plans

1. Claims for Benefits:

If you would like to present a claim for benefits for yourself or your insured dependents, you should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) should be completed by (1) you, (2) the Employer or Administrator and (3) the Attending Physician or hospital.

Following completion, the claim form(s) must be forwarded to the individual authorized to evaluate claims (Administrator or Insurance Company's Claim Representative). The individual authorized to evaluate claims will determine if benefits are payable and, if due, issue payment(s) to you.

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

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

2. Appealing Denial of Claims:

On any wholly or partially denied claim, you or your representative may appeal to us for a full and fair review.

You may:

1. request a review upon written application within 180 days of the claim denial;
2. request, free of charge, copies of all documents, records, and other information relevant to your claim;
and
3. submit written comments, documents, records and other information relating to your claim.

The Insurance Company will make a decision no more than 45 days after we receive your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to the request. The written decision will include specific references to the plan provisions on which the decision is based and any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet

is Insured by the

Hartford Life and Accident Insurance Company
Hartford, Connecticut

Member of The Hartford Insurance Group