YOUR GROUP **WEEKLY DISABILITY INCOME** PLAN

For Employees of

The University of Chicago

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Your Employer provides a Plan of salary continuation (also known as short term Disability benefits) for eligible employees during a Period of Disability. Please contact the Employer for information about the Plan. In the event of any discrepancy between this document and the Plan documents, the Plan documents will govern.

The Employer manages the payment of benefits under the Plan and is considered the Plan Administrator. The Employer has the final responsibility for determining eligibility of covered persons and liability for payment of claims in accordance with the provisions of the Plan.

ReliaStar Life Insurance Company provides Disability management services on behalf of the Employer, as described by the “Disability Management Program” provisions of this document. ReliaStar Life Insurance Company acts only as an agent of the Employer. It is not liable or responsible for the payment of claims under the Plan, nor does it insure the Plan.

SCHEDULE OF BENEFITS

Short Term Disability Coverage
Contact the Employer for information about eligibility, coverage effective and termination dates, and benefit amounts under the Plan.

Benefit Waiting Period
- Disability caused by Accidental Injury .....14 calendar days
- Disability caused by Sickness .....14 calendar days

Maximum Benefit Period

Class 1: Non Union, Non Faculty Employees & Emergency Dispatchers ICOP) ...11 weeks

Class 2: Facilities Skilled Trades and Service Employees – L73,
Police Officers – L185 & Electricians – L134 .....11 weeks

Class 3: Communications Technicians – L134 and Clerical and Service
Employees .....24 weeks

DEFINITIONS

Accidental Injury – bodily injury resulting from a sudden, violent, unexpected and external event. All injuries are considered to be received in one accident as one Accidental Injury. Infection resulting from a cut or wound caused by an accident is also an Accidental Injury.

Accidental Injury does not include poisoning, disease or any other type of infection, except as stated above.

Active Work, Actively at Work – the employee is physically present at his or her customary place of employment with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Disability, Disabled – a change in Your functional capacity to work due to Sickness or Accidental Injury has caused Your inability to perform the Essential Duties of Your Regular Occupation or a Reasonable Employment Option offered to You by the Employer.

Economic factors such as, but not limited to, recession, job obsolescence, paycuts, and job sharing will not be considered in determining whether You meet the requirements stated above.

You will not be considered Disabled solely because of the loss or restriction of Your license to engage in Your Regular Occupation.

Disability Management Program – The evaluation of Your Disability by the Employer or its agent to determine the length of Disability and establish a target date for return to work.

Doctor – a medical practitioner of a healing art which is recognized by applicable state law, who meets all of the following conditions:

- He or she is practicing within the scope of his or her license.
- He or she is certified or credentialed by the appropriate medical or professional board that provides certification or credentialing for practitioners who perform the type of treatment or service the practitioner is providing for Your Sickness or Accidental Injury.
- He or she possesses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat Your condition.

The term Doctor does not include You, an employee of the Employer, anyone related to You by blood or marriage, or anyone living in Your household.

Employer – The University of Chicago.

Essential Duties – duties which are normally required for the performance of an occupation as it is normally performed in the national economy and which cannot be reasonably omitted or modified. If You were normally required to perform essential duties in excess of 40 hours per week or 8 hours per day prior to becoming Disabled, You will be considered to be still able to perform the essential duties if You are working or have the capacity to perform such duties at least 40 hours weekly or 8 hours daily.

Period of Disability – a new Period of Disability begins if the new Disability results from a cause or causes unrelated to that of any previous Disability, separated by Active Work with the Employer. All periods of Disability which have the same cause are considered one Period of Disability. **Exception:** A new Period of Disability begins when You become Disabled due to the same cause after You have been Actively at Work on a full-time basis with the Employer continuously for at least 14 working days.

Plan – the plan of short term Disability coverage provided by the Employer under 72389-4SFDIS.

Reasonable Employment Option – an employment position for which You are able to perform the Essential Duties given Your education, training and experience.

Regular and Appropriate Care – means:

- You personally visit a Doctor as often as is medically required, according to generally accepted medical standards and consistent with the stated severity of Your medical condition, to effectively manage and treat Your Sickness or Accidental Injury.
- You are receiving care which conforms with generally accepted medical standards for treating Your Sickness or Accidental Injury and is consistent with the stated severity of Your medical condition.
- Care is rendered by a Doctor whose specialty or experience is the most appropriate for Your Disability according to generally accepted medical standards.

Regular Occupation – the activity which, immediately prior to Disability, You were regularly performing and which was Your source of income from the Employer. This occupation will be assessed as it is normally performed in the national economy, rather than how the duties and tasks are performed for a specific employer or at a specific location.

Sickness – any physical illness, mental disorder, normal pregnancy or complication of pregnancy.

You, Your – an employee covered for short term Disability coverage under the Plan.

SHORT TERM DISABILITY COVERAGE

Qualifying for Benefits
Benefits are payable under the Plan if You become Disabled and qualify for benefits. To qualify for benefits, all of the following conditions must be met:
You must –

- Be covered on the date You become Disabled and the condition causing Your Disability is not excluded from coverage.
- Be covered on the date the benefit waiting period begins.
- Provide notice of Disability as described in the CLAIMS section.
- Be receiving Regular and Appropriate Care and treatment.
- Have the length of Your Disability approved by the Disability Management Program.

Disability Management Program
The Disability Management Program evaluates Disability to determine the length of Disability and establish a target date for return to work. If Your Disability is expected to continue beyond the number of approved days, You need to notify the Disability Management Program. Benefits are not payable until approval is obtained. Benefits are not payable for non-approved days.

Benefit Waiting Period
The benefit waiting period is the length of time You must be continuously Disabled before You qualify to receive any benefits. **Exception:** You may return to work for up to 10 days during the benefit waiting period without having to begin a new benefit waiting period. The days You work and are not Disabled do not count toward meeting the benefit waiting period.

The benefit waiting period begins on the first day You see a Doctor and he or she states in writing that You are Disabled because of Sickness or Accidental Injury.

The length of the benefit waiting period is shown on the SCHEDULE OF BENEFITS.

Benefit Payments
Contact the Employer for information about benefit payments under the Plan.

Termination of Benefits
Benefits will stop according to the terms of the Plan, for reasons that may or may not relate to Your Disability. Benefits will stop on the earliest of the following dates related to Your Disability:

- The date You are no longer Disabled.
- The end of the maximum benefit period for any one Period of Disability. The maximum benefit period is shown on the SCHEDULE OF BENEFITS.
- The date You fail to provide written proof of Disability that is satisfactory to the Disability Management Program.
- The date You cease to be under Regular and Appropriate Care of a Doctor, or refuse to undergo an examination by a Doctor of the Disability Management Program's choosing.
- The date You refuse to receive medical treatment that is generally acknowledged by Doctors to cure or improve Your condition so as to reduce its disabling effect.
- The date You refuse to work with the assistance of modifications made to Your work environment, functional job elements or work schedule, or adaptive equipment or devices, that a qualified Doctor has indicated will accommodate the limiting factors of Your Sickness or Accidental Injury.

If the Plan terminates after You qualify to receive benefits, the Employer may continue Your benefit payments according to the terms of the Plan on the date You became Disabled.

Recurrent Disability
If You are receiving short term Disability benefits, a recurrent Disability is a Disability due to the same cause which occurs after You have returned to full-time work for the Employer for less than 14 working days.

Benefits are payable for a recurrent Disability which is a continuation of a previous Disability. A recurrent Disability has –

- No additional benefit waiting period.
- The same maximum benefit period as the previous Disability.

Benefits payable under this recurrent Disability provision will stop if benefits are payable to You under any other group disability policy or plan.

Exclusions
Benefits are not payable if Your Disability results from any of the following:

- Sickness or Accidental Injury which occurs in any armed conflict, whether declared as war or not, involving any country or government.
- Sickness or Accidental Injury which occurs while You are on military service for any country or government.
- Intentionally self-inflicted injury or illness, whether You are sane or insane.
- Accidental Injury which occurs when You commit or attempt to commit a felony.
- Accidental Injury suffered in a fight in which You are the aggressor.
- Sickness or Accidental injury due to cosmetic or reconstructive surgery, except for surgery necessary to correct a deformity caused by Sickness or Accidental Injury.
- Sickness or Accidental Injury for which You have or had a right to payment under a workers' compensation or similar law. This includes payment You would have been entitled to receive if the Employer had not declined to provide workers' compensation insurance as allowed by the Employer's state of domicile.
- Sickness or Accidental Injury arising out of or in the course of work for pay, profit, or gain.

Benefits are not payable for the portion of any Period of Disability that You are confined in a penal or correctional institution as a result of conviction for a criminal or other public offense.

No additional benefit will be payable for Disability caused by both Sickness and Accidental Injury or by more than one Sickness or Accidental Injury.

CLAIMS

Free Choice of Doctor
You have the right to choose any Doctor.

Submitting a Claim
You or someone on Your behalf must contact the Disability Management Program in order to submit a Disability claim. The Disability Management Program will gather information from You, the Employer and Your Doctor to determine eligibility and verify proof of Disability.

Benefit Payments
Contact the Employer for information about benefit payments under the Plan.

If Your Disability is expected to continue beyond the number of approved days, You need to notify the Disability Management Program.

Exam
When reasonably necessary, the Disability Management Program may have You examined while You are claiming benefits. The exam will be conducted by one or more Doctors of the Disability Management Program's choice. This will only be exercised as often as the Disability Management Program reasonably believes necessary to properly evaluate Your claim. The Employer has the right to defer or suspend payment of benefits if You fail to attend an exam or fail to cooperate with the Doctor.

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

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

The Association 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 Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

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 Utah law.

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

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800