
CHILDREN TODAY, INC.

864953(GL)1.0 Life and Accidental Death and Dismemberment

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INSURER INFORMATION NOTICE

NOTICE REQUIREMENT

IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT:

**STATE OF CALIFORNIA INSURANCE DEPARTMENT
CONSUMER COMMUNICATIONS BUREAU
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013**

1-800-927-HELP

THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS:

**THE HARTFORD GROUP BENEFIT'S DIVISION
POLICYHOLDER SERVICES, P.O. BOX 2999
HARTFORD, CT 06104-2999
TELEPHONE: 1-800-572-9047**



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 We have issued and delivered the Group Insurance Policy (Policy) to the Policyholder. The Policy insures the Policyholder's employees who:

- are eligible for the insurance;
- become insured; and
- continue to be insured,

according to the terms of the Policy.

The terms of the Policy which affect an employee's insurance are summarized 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 Policy. This Booklet-certificate replaces any other which We may have issued to the Policyholder to give to You under the Policy specified herein.

Richard G. Costello, Secretary

John C. Walters, President

Some of the terms used within this Booklet-certificate are capitalized and have special meanings. Please refer to the definitions at the end of this Booklet-certificate when reading about Your benefits.

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.

The Policyholder: CHILDREN TODAY, INC.
The Policy Number: GL-864953
Policy Effective Date: March 1, 2009
Anniversary Date: March 1 of each year, beginning in 2010.

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

When will You become eligible? (Eligibility Waiting Period)

If You are working for the Employer prior to the Policy Effective Date and are covered under the Prior Plan, You are eligible for coverage on the later of the Policy Effective Date or the date You enter an eligible class.

If You start working for the Employer after the Policy Effective Date, You are eligible for coverage on the first day of the month coincident with or next following the date on which You complete a waiting period of 1 month(s) of continuous service.

What is Evidence of Good Health?

Evidence of Good Health is information about a person's health from which We can determine if coverage or increases in coverage will be effective. Information may include questionnaires, physical exams, or written documentation as required by Us.

Inquiries as to the status of Your submission of Evidence of Good Health should be addressed to Your Employer and/or Benefit Administrator. We, Your Employer and/or Benefit Administrator will notify You of approvals. We will notify You, in writing, of any disapprovals.

When will Evidence of Good Health be required?

Evidence of Good Health is required if You elect no coverage when eligible to do so and later opt for coverage for any Amount of Life Insurance for Yourself.

Evidence of Good Health must be provided at Your own expense.

If Evidence of Good Health is not approved in the situation(s) described above, no coverage will become effective.

AMOUNT OF LIFE INSURANCE Employee Only

What Life benefits are available to You?

Amount of Life Insurance:
An amount equal to \$30,000.

Your Amount of Life Insurance will be reduced by any life benefit:

1. paid to You under an accelerated death benefit in the Prior Plan; and
2. in force for You under any disability extension provision of the Prior Plan.

If You convert, does it affect the Amount of Life Insurance benefit payable?

The Amount of Life Insurance under the Policy will be reduced by the amount of the individual life insurance issued in accordance with the Conversion Privilege for reasons other than reductions in coverage.

**ACCIDENTAL DEATH, DISMEMBERMENT
AND LOSS OF SIGHT BENEFIT (AD&D)
Employee Only**

What AD&D Benefits are available to You?

Principal Sum:

An amount which equals the Amount of Life Insurance in force for You.

The Principal Sum will not exceed the Amount of Life Insurance for which You are insured.

REDUCED AMOUNTS OF INSURANCE

What reductions in Your coverage will occur due to Your age?

Your Amount of Life Insurance and Principal Sum will decrease on the date You attain any of the ages specified in the following table. The Amount of Life Insurance and Principal Sum in force immediately prior to that date will be reduced by the percentage indicated in the following table.

Additionally, if:

1. You become insured under the Policy; or
2. Your coverage increases,

on or after the date You attain age 65, We reduce the amount of coverage for which You would otherwise be eligible in the same manner.

Age When Reduction Occurs	65	70	75	80	85	90	95
Percentage by which current amount of coverage (after all previous reductions) will be reduced	35%	35%	35%	25%	25%	25%	25%

Reduced amounts of Life Insurance and Principal Sum will be rounded to the next higher multiple of \$500, if not already such a multiple.

ELIGIBILITY AND ENROLLMENT

Must You contribute toward the cost of coverage?

With respect to Life Insurance and AD&D coverage, You do not contribute toward the cost.

How do You request coverage for Yourself?

If You are not required to contribute toward the cost of coverage, You are not required to request coverage. Enrollment will be automatic. However, You will be required to complete a beneficiary election form.

When does coverage start?

If You are not required to contribute toward the cost of coverage, You will become insured on the date You become eligible for coverage.

All effective dates of coverage are subject to the Deferred Effective Date provision.

What is the Deferred Effective Date provision for employees?

If You are absent from work due to a physical or mental condition on the date Your insurance, an increase in coverage or a new benefit added to the Policy would otherwise have become effective, the effective date of Your insurance, any increase in insurance or the additional benefit will be deferred until the date You return to work as an Active Full-time Employee.

Are there exceptions to the Deferred Effective Date provision?

If You were insured under the Prior Plan on the day before the Policy Effective Date and You would be eligible for coverage on the Policy Effective Date except that You are not able to meet the requirements of the Deferred Effective Date provision, then:

1. the Deferred Effective Date provision will not apply to the original effective date of coverage; and
2. the coverage amount shown in the Schedule of Insurance will not apply to You.

Instead, You will be considered to be insured and Your coverage amount will be the lesser of:

1. the Amount of Life Insurance and Principal Sum under the Prior Plan; or
2. the Amount of Life Insurance and Principal Sum shown in the Schedule of Insurance,

reduced by:

1. any coverage amount in force or otherwise payable due to any disability benefit extension under the Prior Plan; or
2. any coverage amount that would have been in force due to any disability benefit extension under the Prior Plan had timely election for the disability provision been made.

You will remain insured under this provision until the first to occur of:

1. the date You return to work as an Active Full-time Employee;
2. the date Your insurance terminates for a reason stated under the Termination provision;
3. the last day of a period of 12 consecutive months which begins on the Policy Effective Date; or
4. the last day You would have been covered under the Prior Plan, had the Prior Plan not terminated.

When are changes effective?

The provisions, terms and conditions of the Schedule of Insurance or this Booklet-certificate may be modified, amended or changed at any time; consent from any covered individual is not required.

If there is any type of change in Your class, the Schedule of Insurance or the Booklet-certificate which:

1. decreases an amount of coverage or deletes, limits or restricts the availability of a benefit or provision, then that decrease, deletion, limitation or restriction will be effective on the date the change in class, the Schedule of Insurance or the Booklet-certificate is effective;
2. increases an amount of coverage or adds, improves or increases availability of a benefit or provision, then that increase, addition or improvement will be effective on the date the change in class, the Schedule of Insurance or the Booklet-certificate is effective, subject to application of the Deferred Effective Date provision and Our approval where Evidence of Good Health is required.

BENEFITS

Life Insurance Benefit

To whom and how are benefits paid?

A completed claim form, a certified copy of the death certificate and Your enrollment form must be sent to the Employer or Us. When the required claim papers are received and approved by Us, the Amount of Life Insurance will be paid.

Your death benefit will be paid in a lump sum to the beneficiary(ies) designated by You in writing and on file with the Employer.

Unless You have requested something different, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share.
2. If any named beneficiary dies before You, His share will be divided equally among the named surviving beneficiaries.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

1. up to \$500 of Your life insurance to any party that We deem is entitled because of their payment of burial expenses. We will be released from further liability for any amount so paid; and/or
2. the executors or administrators of Your estate; or
3. Your surviving relatives in the following order:
 - a) all to Your surviving spouse; or
 - b) if Your spouse does not survive You, in equal shares to Your surviving children; or
 - c) if no child survives You, in equal shares to Your surviving parents.

If a minor does not have a legal guardian, We may, until such a guardian is appointed, pay the person We deem to be caring for and supporting him. Such payment will be in monthly installments of not more than \$200.

If a death benefit payable meets Our guidelines, then the benefit is payable into a checking account. Your beneficiary owns the checking account. A lump sum payment may be elected by writing a check for the full amount in the checking account.

Accelerated Death Benefit

What is the benefit?

If You are diagnosed as being Terminally Ill and proof of such diagnosis is provided by an attending physician licensed to practice in the United States, and You are:

1. less than age 60; and
2. insured for at least \$10,000,

then You may request that a portion of Your Amount of Life Insurance be paid to You prior to death.

The request cannot exceed 80% of the in force Amount of Life Insurance, and is subject to a minimum of \$3,000 and a maximum of \$500,000. You may exercise this option only once per person.

For example, if You have an Amount of Life Insurance equal to \$20,000 and You are Terminally Ill, You can request any portion of the life insurance between \$3,000 to \$16,000 to be paid to You now instead of to Your beneficiary at Your death. However, if You decide to request only \$3,000 now, You cannot request the additional \$13,000 in the future.

What does Terminal Illness/Terminally Ill mean?

Terminally Ill or Terminal Illness means that an individual has a life expectancy of 12 months or less.

RECEIPT OF ANY BENEFITS IN ACCORDANCE WITH THIS PROVISION WILL REDUCE LIFE INSURANCE BENEFITS PAYABLE UPON DEATH.

What if an individual is no longer Terminally Ill?

If diagnosed as no longer Terminally Ill, coverage may or may not remain in force. Coverage which remains in force will be reduced by any amount of Accelerated Death Benefits received and premium is due for this reduced amount. If coverage does not remain in force, then the reduced amount of coverage may be converted.

What limitations apply to this benefit?

The Accelerated Death Benefit provision will be subject to all applicable terms and conditions of the Policy.

No Accelerated Death Benefit will be paid if You are required by law to accelerate benefits to meet the claims of creditors, or if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement.

What if You made an assignment under this plan?

If You have executed an assignment of rights and interest with respect to Your Amount of Life Insurance, in order to pay benefits to You under this provision, We must receive a release from the individual to whom the assignment was made before any benefits are payable.

**Accidental Death and Dismemberment (AD&D) Benefit
Employee Only**

What conditions are necessary for benefits to become payable?

We will pay a benefit if You suffer an accidental injury while insured and:

1. a Loss results directly from such injury, independent of all other causes; and
2. such Loss occurs within 365 days after the date of the accident causing the injury.

When should We be notified of a claim?

A claimant must give Us, or Our appropriate representative, written notice of a claim within 20 days after the Loss happens or starts. If notice cannot be given within that time, it must be given as soon as possible after that.

Such notice must include:

1. the claimant's name and address; and
2. the Policy or account number.

Are special forms required to file a claim?

Within 15 days of receiving a notice of claim, We or Our appropriate representative will send forms to the claimant for providing proof of Loss. If the forms are not provided within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of claim.

When must proof of Loss be given?

Satisfactory written proof of Loss must be sent to Us or Our appropriate representative, within 90 days after the date of such Loss. However, all claims must be submitted to Us within 90 days of the date any individual's insurance terminates.

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 no later than a year after it is due unless the claimant is not legally competent.

When and to whom will Your claim be paid?

Benefits for Loss of life will be paid in accordance with Your life insurance beneficiary designation. Unless otherwise specified, benefits for all other Losses are payable to You.

Benefits for all other Losses will be paid as soon as due written proof is received. Benefits for all other Losses will be paid not more than 60 days after written proof is received.

Any payments other than for Loss of life which are owing at Your death may be paid to Your estate. If any payment is owed to:

1. Your estate;
2. a person who is a minor; or
3. a person who is not legally competent,

then We may pay up to \$1,000 to Your relative who is entitled to it in Our opinion. Any such payment shall fulfill Our responsibility for the amount paid.

What types of injuries are excluded from coverage?

No benefit will be paid for a Loss caused or contributed to by:

1. sickness;
2. disease;
3. any medical treatment for items (1) or (2);
4. any infection, except a pus-forming infection of an accidental cut or wound;
5. war or any act of war, whether war is declared or not;
6. any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7. any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;
8. taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered by a licensed physician; or
9. the injured person's intoxication.

Intoxication means that blood alcohol content or the results of other means of testing blood alcohol level, meet or exceed the legal presumption of intoxication under the law of the state where the accident took place.

What is the benefit payable?

The benefit payable for any Loss is that which is shown opposite the Loss in the following schedule. The Principal Sum is shown in the Schedule of Insurance. No benefit is payable for any Loss which is not shown in the schedule below.

<u>DESCRIPTION OF LOSS</u>	<u>BENEFIT</u>
Loss of life	Principal Sum
Loss of a hand	One-half the Principal Sum
Loss of a foot	One-half the Principal Sum
Loss of an eye	One-half the Principal Sum
Loss of speech or hearing	One-half the Principal Sum
Loss of thumb and index finger on either hand	One-quarter the Principal Sum
Loss of movement of both upper and lower limbs (Quadriplegia)	Principal Sum
Loss of movement of three limbs (Triplegia)	Three-quarters the Principal Sum
Loss of movement of both lower limbs (Paraplegia)	Three-quarters the Principal Sum
Loss of movement of both upper and lower limbs on one side of the body (Hemiplegia)	One-half the Principal Sum
Loss of movement of one limb (Uniplegia)	One-quarter the Principal Sum
More than one of the above resulting from one accident	Principal Sum or the sum of the Benefits payable for each Loss, whichever is lesser.

Loss means the following:

1. Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint.
2. Loss of an eye means that sight in the eye is completely lost and cannot be recovered or restored.
3. Loss of speech or hearing means that speech or hearing is lost entirely and the Loss cannot be recovered or restored. Hearing must be lost in both ears.
4. Loss of movement of limbs means that the movement is completely lost and is irreversible.
5. Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

Seat Belt/Air Bag Benefit

Subject to all conditions and limitations of this AD&D Benefit, if You suffer a Loss under the AD&D Benefit, while:

1. a passenger riding in; or
2. the licensed operator of,

an Automobile and, at the time of the accident, You were properly wearing a Seat Belt as verified on the police report, then a Seat Belt Benefit will be payable in addition to the Principal Sum.

What is the Seat Belt Benefit payable?

The Seat Belt Benefit payable is the lesser of:

1. 10% of the Principal Sum; or
2. \$10,000.

What conditions are necessary for an Air Bag Benefit to become payable?

If a Seat Belt Benefit is payable, We will pay an additional 5% of the Principal Sum, subject to a maximum of \$5,000, as an Air Bag Benefit, provided that:

1. You were positioned in a seat that was equipped with a factory installed Air Bag;
2. You were properly strapped in the Seat Belt when the Air Bag inflated; and
3. the police report establishes that the Air Bag inflated properly upon impact.

Air Bag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications, that inflates upon collision to protect an individual from injury and death. An Air Bag is not considered a Seat Belt.

Automobile means a duly registered, four wheeled, private passenger car, pick-up truck, van, self-propelled motor home or sport utility vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Employer, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications.

Repatriation Benefit

Subject to all conditions and limitations of this AD&D Benefit, if You die, then a Repatriation Benefit will be paid in addition to the Principal Sum. For a Repatriation Benefit to be payable, the death must occur outside the territorial limits of the state or country of Your place of permanent residence.

What is the Repatriation Benefit payable?

The Repatriation Benefit payable is the lesser of:

1. the expense incurred for:
 - a) preparation of Your body for burial or cremation; and
 - b) transportation of Your body to the place of burial or cremation; or
2. 5% of the Principal Sum; or
3. \$5,000.

TERMINATION Employee Coverage

When does Your coverage terminate?

Unless continued in accordance with the Exceptions to Termination section, Your insurance will terminate on the first to occur of:

1. the date the Policy terminates;
2. the last day of the period for which You made any required premium contribution, if You fail to make any further required contribution;
3. the date You are no longer in a class eligible for coverage;
4. the date Your Employer terminates Your employment; or
5. the date You are absent from work as an Active Full-time Employee.

EXCEPTIONS TO TERMINATION

Under what conditions can Your insurance be continued under the continuation provisions?

If You are absent from work as an Active Full-time Employee, Your insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:

1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are on a documented leave of absence, all of Your coverages may be continued until the last day of the month following the month in which the leave of absence commenced.

If You are laid off due to lack of work, all of Your coverages may be continued until the last day of the month following the month in which the layoff commenced.

If Your employment status changes from Full-time to Part-time, all of Your coverages may be continued for 3 consecutive month(s) following the date of such change in employment status.

If You are absent from work due to sickness or injury, all of Your coverages may be continued until the last day of a period of 12 month(s) which begins on the date You were first absent from work as an Active Full-time Employee. If You feel that Your condition may continue for an extended period of time, You should request that Your Employer file a waiver of premium claim.

What is Waiver of Premium?

Waiver of premium is a provision which allows for continued employee life insurance, without payment of premium, while You are Disabled.

To what coverages does the Waiver of Premium apply?

These provisions apply only to Your Life Insurance.

Waiver of Premium does not apply to any AD&D Insurance.

What conditions must be satisfied before You qualify for Waiver of Premium?

1. You must be less than age 60, insured and Disabled; and
2. acceptable proof of Your condition must be furnished to Us within one year of Your last day of work as an Active Full-time Employee.

What does Disabled mean?

Disabled means that You have a condition that prevents You from doing any work for which You are or could become qualified by education, training or experience and it is expected that this condition will last for at least nine consecutive months from Your last day of work as an Active Full-time Employee; or You have been diagnosed with a life expectancy of 12 months or less.

When will We waive premium?

We will waive premium after proof that You are Disabled is provided by an attending physician licensed to practice in the United States and We approve the proof. You will be notified by Us of the date We will begin to waive premium.

Continued coverage will be subject to any age reductions provided by any part of the Policy.

What if You die before You qualify for Waiver of Premium?

If:

1. You should die within one year of Your last day of work as an Active Full-time Employee but prior to qualifying for waiver of premium; and
2. You were Disabled,

We will pay the Amount of Life Insurance which is in force for You.

Can We have You examined for proof that You continue to be Disabled?

During the first two years following the date You qualify as Disabled, We may have You examined at reasonable intervals. Thereafter, We will only require an annual examination to confirm that You continue to be Disabled. If You fail to submit any required proof or refuse to be examined as required by Us, then Your coverage will terminate.

What if You are no longer Disabled?

If, for any reason, You are no longer Disabled, Your premium will no longer be waived. On that date, You may or may not return to work.

If You return to work in an Eligible Class, then all of Your coverages will be reinstated subject to the terms of the Policy in effect on the reinstatement date.

If You do not return to work within an Eligible Class, and You are not eligible for any other group life insurance, then You are entitled to the Conversion Privilege. You may convert the Amount of Life Insurance that is in force for You on the date it is determined that You are no longer Disabled.

How long will premiums be waived?

Your premium will be waived and Your coverage will be continued until You attain Normal Retirement Age.

On the date waiver of premium terminates, if You do not return to work, You will be entitled to convert Your coverage. You may convert no more than Your Amount of Life Insurance that is in force on the date waiver of premium terminates.

What if the Policy terminates before You qualify for waiver of premium?

If the Policy terminates before You qualify for waiver of premium, You may be eligible to convert. Additionally, You may later be approved for waiver of premium.

What if the Policy terminates after You qualify for waiver of premium?

Termination of the Policy will not affect Your coverage under the terms of this provision.

CONVERSION PRIVILEGE

The following does not apply to any AD&D Benefits.

When can an individual convert?

If insurance, or any portion thereof, terminates, then any individual covered under the Policy may convert his life insurance to a conversion policy without providing Evidence of Good Health.

If the qualifying event is policy termination or termination of coverage for a class then the individual must have been insured for at least 5 years under the Policy in order to be eligible for this conversion privilege.

What is the conversion policy?

The conversion policy will:

1. be on one of the life insurance policy forms, except term insurance, then customarily issued by Us for conversion purposes;
2. contain no disability, supplementary or AD&D benefits; and
3. be effective on the 32nd day after group life insurance terminates.

How much can be converted?

If the qualifying event is policy termination or termination of coverage for a class, then the amount which may be converted is limited to the lesser of:

1. the amount of group coverage in force prior to the qualifying event, reduced by the amount of any other group coverage for which the individual becomes covered within 31 days of termination of group coverage; or
2. \$2,000.

If conversion is due to retirement or any other qualifying event, the full amount of coverage lost may be converted.

How does an individual convert coverage?

To convert life insurance, the individual must, within 31 days of the date group coverage terminates, make written application to the Us and pay the premium required for his age and class of risk.

What if death occurs during the conversion election period?

If the individual should die within the 31 day conversion election period, We will, upon receipt of acceptable proof of His death, pay the Amount of Life Insurance He was entitled to convert.

GENERAL PROVISIONS

When can this plan be contested?

Except for non-payment of premium, the Policy cannot be contested after two years from the Policy Effective Date.

No statement relating to 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 the individual's lifetime. In order to be used, the statement must be in writing and signed by the affected individual.

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 Policy.

Are there any rights of assignment?

Except for the dismemberment benefits under the AD&D Benefit, You have the right to absolutely assign all of Your rights and interest under the Policy including, but not limited to, the following:

1. the right to make any contributions required to keep the insurance in force;
2. the privilege of converting; and
3. the right to name and change a beneficiary.

However, You may not assign rights to the Employer, and if You are terminally ill, You may not make an absolute assignment if the benefits under the Policy would be used as collateral for a loan.

No absolute assignment of rights and interest shall be binding on Us until and unless:

1. the original of the form documenting the absolute assignment; or
2. a true copy of it,

is received and acknowledged by Us at our home office.

We have no responsibility:

1. for the validity or effect of any assignment; or
2. to provide any assignee with notices which We may be obligated to provide to You.

How do You designate or change Your beneficiary?

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

In no event may a beneficiary be changed by a Power of Attorney.

What recourse do You have if Your claim is denied?

On any claim, the claimant or His representative must appeal to Us for a full and fair review.

1. You must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires a determination of disability, or
 - b) 60 days of receipt of claim denial for all other claims; and
2. You may request copies of all documents, records, and other information relevant to Your claim; and
3. You may submit written comments, documents, records, and other information relating to Your claim.

We will respond to You in writing with our final decision on Your claim.

Can We have a claimant examined or request an autopsy?

We reserve the right to have a claimant examined and to have an autopsy performed, if not forbidden by law. Any such examinations will be as reasonably required by Us and at Our expense.

What notification will You receive if Your claim is denied?

If a claim for benefits is wholly or partly denied, the claimant 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 provisions upon which the denial is based; and
3. provide an explanation of the review procedure.

When can legal action be taken?

Legal action cannot be taken against Us:

1. sooner than 60 days after proof of loss has been furnished; or
2. 3 or more years after the time proof of loss is required to be furnished according to the terms of the Policy.

How does this plan affect Workers' Compensation coverage?

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Physician-patient Relationship

You may choose any licensed physician. We shall not in any way disturb the physician-patient relationship.

DEFINITIONS

Active Full-time Employee – An employee who works for the Employer on a regular basis in the usual course of the Employer's business. An employee must work at least the number of hours in the Employer's normal work week. This must be at least 30 hours. You will be considered 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 also be considered actively at work on a paid vacation day or 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.

Anniversary Date – The date occurring in each calendar year which is an anniversary of the Policy Effective Date.

Employer – The Policyholder named in the Schedule of Insurance.

He/His – He or she. His or her.

Normal Retirement Age – 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.

Prior Plan – A plan of group term life insurance sponsored by the Employer which was in force on the day before the Policy Effective Date.

We/Us/Our – The Hartford Life and Accident Insurance Company.

You/Your – The employee to whom this Booklet-certificate is issued.

ERISA INFORMATION

**THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION**

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy is incorporated into, and forms a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

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

1. Plan Name

Group Life Plan for employees of CHILDREN TODAY, INC..

2. Plan Number

LIFE - 501

ADD - 501

3. Employer/Plan Sponsor

CHILDREN TODAY, INC.
1900 E. South Street
Long Beach, CA 90805

4. Employer Identification Number

95-4635295

5. Type of Plan

Welfare Benefit Plan providing Group Life.

6. Plan Administrator

CHILDREN TODAY, INC.
1900 E. South Street
Long Beach, CA 90805

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

For the Plan

CHILDREN TODAY, INC.
1900 E. South Street
Long Beach, CA 90805

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.
-

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

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. 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 Employee Benefits Security 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 the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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 Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits 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.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy.

Claim Procedures for Claims Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed 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 may 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. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy 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 Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final 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 individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, we will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Policy provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim; 5) (A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, 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 decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Policy to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy 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, and 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.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) 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