

1. General Plan Information

1.01 What is contained in this document?

This document describes the Short Term Disability (STD) Plan (the “Plan”) and provides certain information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Plan is a welfare benefit plan as defined in ERISA. Sprint’s costs of providing benefits under the Plan are financed out of its general assets, and, in some states, by purchasing disability insurance.

In this document Sprint means Sprint Corporation and is sometimes referred to as “we” or “us.” We refer to participants as “you.”

1.02 What is the purpose of the Plan?

If you qualify for benefits, this Short Term Disability (STD) Plan provides income protection when you cannot work at your usual job due to an injury or illness incurred either on or off the job. This Summary Plan Description (SPD) describes the benefits and coverage requirements for the benefits.

1.03 Who administers the Plan?

The plan administrator as defined by ERISA is the Employee Benefits Committee. The Employee Benefits Committee is granted the authority to control and manage the operation and administration of the Plan. This authority includes the discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

The Employee Benefits Committee has delegated day-to-day administrative responsibilities to the Director, Benefits Services, whose address currently is:

Sprint
Attention: Director, Benefits Services
6500 Sprint Parkway
Mailstop: KSOPHL0302-3A
Overland Park, Kansas 66251

Sprint is also the Plan sponsor. Sprint’s Federal employer identification number is 48-0457967.

1.04 Which Sprint subsidiaries participate in the Plan?

Sprint and its subsidiaries that participate in the Plan, called “Participating Employers,” are listed below:

Sprint Corporation
Carolina Telephone and Telegraph Company

Centel Corporation
Centel Directory Company
Central Telephone Company
Central Telephone Company of Texas
Central Telephone Company of Virginia
North Supply Company
Sprint - Florida, Inc.
Sprint Mid-Atlantic Telecom, Inc.
Sprint - Minnesota, Inc.
Sprint - Missouri, Inc.
Sprint Telecenters, Inc.
Sprint/United Management Company
Sprint/United Midwest Management Services Company
The United Telephone Company of Pennsylvania
UCOM, Inc.
United Telephone - Southeast, Inc.
United Telephone Company of Indiana, Inc.
United Telephone Company of Kansas
United Telephone Company of New Jersey, Inc.
United Telephone Company of Ohio
United Telephone Company of Texas, Inc.
United Telephone Company of the Carolinas
United Telephone Company of the Northwest
United Telephone Company of the West
US Telecom, Inc.

1.05 What is the effective date of the Plan?

This Plan is effective July 6, 2003. We refer to this date as the “Effective Date.” Benefits are available to covered Participants under this Plan beginning July 6, 2003. This Plan supersedes any other plan providing benefits for income protection to employees of Participating Employers as of this Plan’s Effective Date. We refer to these other plans as “Prior Plans” in this SPD.

2. Plan Coverage

2.01 Who is covered by the Plan?

You are covered by the Plan if you meet all of the following coverage criteria:

- Work for a Participating Employer,
- Are not represented by a labor union, or you are represented by a labor union that has bargained for coverage under this Plan, :
- Meet one of the Plan’s service requirement described in section 2.02
- Are a regular, full-time employee, or a regular, part-time employee scheduled to work 20 or more hours per week.

- Work in a job grade below E-14 (grades E-14 and above are covered by a different policy).

You are not covered by the Plan:

- If you do not meet any of the conditions for eligibility set forth above;
- After your last day worked when your employment with a Participating Employer ends for any reason;
- During any unpaid leave, other than leave under the Family and Medical Leave Act; or
- If this Plan is terminated.

2.02 *What are the Plan's service requirements?*

Your service requirement depends on your employment status on the Plan's Effective Date.

- If you were covered by a Prior Plan on the Effective Date, you will have met this Plan's coverage requirement on the Effective Date.
- If you were an employee of a Participating Employer on the Effective Date, but were not covered by a Prior Plan on that date, you will meet this Plan's service requirement on the date that you would have been covered under the Prior Plan.
- If you were hired on or after the Effective Date, you will meet this Plan's service requirement when you have completed one year of continuous service with a Participating Employer.

2.03 *Who is a "regular full-time" or "regular part time" employee?*

The terms "regular full-time" and "regular part-time" employee refers to your designation in Sprint's payroll system. Employees with a "temporary" designation are not "regular" employees. An individual who is not treated as a "regular" employee on the payroll records of a Participating Employer is not eligible for this Plan, even if a court or administrative agency determines the individual is a common law or other employee of a Participating Employer.

3. *Plan Benefits*

3.01 *When am I entitled to benefits under the Plan?*

If you are covered under the Plan, you are entitled to benefits when you meet all of the following criteria:

- You cannot work due to an illness or injury you incur either on or off the job;
- Your absence due to that illness or injury is for more than 40 consecutive scheduled work hours (we refer to this period as the "Waiting Period"); and
- You comply with the Claims Procedure described in Section 5.01 of the Plan

You are not entitled to benefits under the Plan if any of the following apply to you:

- You are not covered by the Plan;
- You qualify for, or are receiving, benefits under a Prior Plan;
- You engage in any activity inconsistent with your application for STD benefits;
- You provide services to any other entity as an employee, consultant, contractor or volunteer;
- The health care providers signing any required forms under the Plan are not licensed by the state or states where the health care providers practice;
- You are not receiving care and treatment that is appropriate or consistent with your illness or injury;
- You have cosmetic surgery, except in cases where the cosmetic surgery is associated with an illness or injury;
- Fail to undergo an Independent Medical Examination (as that term is defined later in the Plan) the Plan Administrator deems necessary;
- You refuse to work if a Participating Employer is willing to make accommodations to any restrictions associated with your illness or injury;
- Your illness or injury is in conjunction with your confinement in a penal or correctional institution; or
- Your illness or injury is:
 - Caused by armed conflict;
 - The result of an illegal activity, including felonies, or attempted felonies;
 - Intentionally self-inflicted;
 - The result of your active participation in a riot or act of terrorism.

You are employed at-will, meaning you or Sprint can terminate your employment at any time, with or without cause or notice. If your employment with a Participating Employer is involuntarily terminated (i.e., someone other than you ends your employment) while you are receiving STD benefits, you may continue receiving benefits until (i) your benefits are exhausted, (ii) your health care provider indicates you could have otherwise returned to work, with or without restrictions, or a health care provider providing an IME indicates you could have otherwise returned to work, with or without restrictions.

3.02 Who determines if my illness or injury prevents me from working?

As described in the Claims Procedure in section 5.01, your health care provider must certify that you are unable to work due to your illness or injury and set your return to work date. We may also require that you undergo an IME.

3.03 What is an IME?

An IME is an independent medical examination. For the IME, the Plan selects a health care provider who examines you to determine if you can work, and if not, whether your inability to work is a result of an illness or injury. If a health care provider performing an IME under the Plan determines you can work, with or without restrictions, your benefits

under the Plan will cease. That is, you will not receive any further STD benefits unless health care provider performing an IME under the Plan determines you can not work due to an injury or illness. If the health care provider performing an IME under the Plan indicates you are able to work, or, if you are unable to work, but not because of an illness or injury, the health care provider performing the IME under the Plan has final say and benefits will cease, even if your own doctor says you can not work due to an injury or illness.

Your STD benefits may be suspended while an IME is pending.

3.04 *If I become entitled to benefits under the Plan, how are my benefits determined?*

Benefits under the Plan are based upon your length of service with Participating Employers. The Plan provides benefits up to a maximum of 26 weeks according to the following STD Benefit Payment Schedule

STD Benefit Payment Schedule

If your length of service is:	Then benefits at 100% of Base Salary are paid for:	And benefits at 60% of Base Salary are paid for:
Less than one year	None, but you may be entitled to benefits under a Prior Plan	None, but you may be entitled to benefits under a Prior Plan
One year of service or more	Two weeks of STD benefits at 100% of your Base Salary for each full year of service up to a maximum of 26 weeks	26 weeks of STD benefits at 60% of your Base Salary, less the number of weeks of benefits at 100% of your Base Pay

3.05 *If I become entitled to benefits under the Plan, when will they begin?*

Your STD benefits will begin after your Waiting Period as described in 3.01.

3.06 *If I become entitled to benefits under the Plan, when will they end?*

Your STD benefits cease when any of the following apply to you:

- Your health care provider or a health care provider performing an IME under the Plan indicates you may return to work, with or without restrictions associated with your illness or injury;
- You receive the maximum amount of benefits you are entitled to under the Plan;
- You reach the end of
 - your separation pay period under the Sprint Separation Plan, or
 - your notice period under the Workers Adjustment and Retraining Notification Act (“WARN”), or the period during which you receive severance pay in lieu of notice under WARN
- If you begin receiving benefits under the Plan after you are notified in writing that your position with a Participating Employer will be eliminated (as explained in Section 4.01); or
- You are no longer eligible or qualified to receive benefits under the Plan;

Your job will generally be held open for you while you receive benefits under the Plan. However, nothing in this Plan should be construed as a limitation by a Participating Employer to eliminate positions or otherwise reorganize its operations.

If you can not return to work when you are no longer eligible for benefits under the Plan, it is your responsibility to contact management and Human Resources to discuss your continued employment.

3.07 What is my Base Salary for purposes of determining my STD benefits?

STD benefits are based upon your Base Salary on your last day worked. If you are an exempt employee, your Base Salary is your weekly salary. If you are a non-exempt employee, your Base Salary is your hourly rate times your regularly scheduled weekly work hours. If you are eligible to participate in the Management Incentive Plan (MIP), sales incentive compensation plans, or any other similar compensation plans, you will earn incentive compensation, if any, according to the terms and conditions of such plans while you receive benefits under this Plan. Payments under the Management Incentive Plan (MIP), sales incentive compensation plans, or any other similar compensation plans are not included in your Base Salary for purposes of this Plan. Payments such as overtime and shift differentials, are not included in your Base Salary for purposes of this Plan.

3.08 What happens if my health care provider does not release me on my original return to work date?

You must provide the Health Care Provider Extension Form on or before the original return to work date. If an extension form is not completed within the above timeframe, STD benefits will suspend and may be denied.

3.09 What must I do before I can return to work?

You must provide documentation from your health care provider indicating you are able to return to work with or without restrictions. We call this documentation a “Medical Release Form.”

3.10 What happens if I do not provide a Medical Release Form?

You will not be permitted to return to work and STD benefits will cease.

3.11 What if my doctor will not release me to return to work on a full-time basis, but will release me to work part-time?

You may qualify for partial benefits under the Plan if (i) your health care provider, or a health care provider performing an IME under the Plan, indicates you are able to return to work on a part-time basis (i.e., less than your regularly scheduled weekly or daily work hours), and (ii) a part-time schedule is consistent with the Participating Employer’s allowable schedules of work. In order to qualify for partial benefits under the Plan, your health care provider, or a health care provider performing an IME under the Plan, must determine you are capable of working on a part-time basis and that you will be able to return to full-time within 90 days. Employees who can only return to work on a part-time basis permanently do not qualify for partial benefits under the Plan.

3.12 If I return to work after receiving Plan benefits, and I become entitled to Plan benefits a second time, must I satisfy the Waiting Period again?

Yes, your Plan benefits will not begin until after the Waiting Period described in section 3.01 unless

- you are entitled to Plan benefits the second time due to the same illness or injury that caused you to be entitled to Plan benefits the first time; and
- you returned to work for 30 calendar days or less.

However, if your Plan benefits the first time ended because an IME determined you could return to work, you will be required to satisfy the Waiting Period again before further benefits may become available.

3.13 If I return to work after receiving Plan benefits, and I become entitled to Plan benefits a second time, do I start over on the STD Benefit Payment Schedule described in section 3.04?

If you return to work for less than 182 calendar days, your previous STD benefits will be considered in determining the amount and maximum period of benefits. In other words, you will continue on the STD Benefit Payment Schedule described in section 3.04 based on your service at the first time you became entitled to Plan benefits.

If you return to work for at least 182 calendar days, your previous STD benefits will not be considered in determining the amount and maximum period of benefits.

Example #1: An employee has worked for a Participating Employer for two years and 11 months when she becomes entitled to benefits under the Plan due to an illness. Assume she cannot work due to this illness for six weeks. Based on the STD Benefit Payment Schedule, she receives five weeks of STD benefits, following the Waiting Period, – four weeks at 100% of Base Salary (i.e., two weeks for each of her two complete years of service) and one week at 60% of Base Salary. Four months after returning to work, the employee again becomes entitled to Plan benefits. Because her five weeks of prior STD is considered in determining benefits, her maximum benefit for this second disability is 21 weeks. All 21 weeks will be at 60% of Base Salary.

Example #2: Assume the same facts as Example #1, except that the employee works for eight months, rather than four months, after returning from her first disability. Because her five weeks of prior STD is not considered in determining benefits, her maximum benefit for this second disability is 26 weeks. Six weeks will be at 100% of Base Salary (i.e., two weeks for each of her three complete years of service) and 20 weeks will be at 60% of Base Salary.

3.14 What happens if I am overpaid STD benefits?

Overpayments occur when you receive more STD benefits that you are entitled to receive under the Plan. The Plan may recover the overpayments by offsetting such amounts against future payments under the Plan or any other method permitted by applicable law.

4. Coordination with Other Compensation and Benefit Plans

4.01 How do STD benefits coordinate with other plans?

STD benefits coordinate with the Sprint Separation Plan based on when you are notified in writing that your position will be eliminated.

- If you are receiving STD benefits under this Plan when you are notified in writing that your position will be eliminated, you will continue receiving the STD benefits you are entitled to under this Plan and your separation benefits under the Sprint Separation Plan will begin thereafter.
- If you begin receiving STD benefits under this Plan after written notification, you will receive any STD benefits you are entitled to under this Plan only until your separation pay period ends under the Sprint Separation Plan and your STD benefits under this Plan will be offset by any severance benefits you receive under the Sprint Separation Plan or payments made in lieu of notice under WARN or any similar state or local laws.

These rules are illustrated by the following examples

Example #1: An employee who has worked continuously for a Participating Employer since July 1, 1995, is notified in writing on November 3, 2003 that his position will be eliminated and his last day worked will be November 14, 2003. Because he has eight years of service, he is entitled to 16 weeks of separation pay. Suppose the employee began receiving benefits under the Short-Term Disability Plan on October 27, 2003 and is set to return to work on November 24, 2003. Based on these facts, the employee will receive four weeks of short-term disability benefits (from October 27, 2003 through November 21, 2003) and 16 weeks of separation pay (from November 24, 2003 through March 12, 2004).

Example #2: Suppose the same facts as Example #1, except that the employee begins receiving benefits under the Short-Term Disability Plan on November 10, 2003 and is set to return to work on November 24, 2003. Based on these facts, the employee will receive short-term disability benefits for the week of November 10, 2003. His short-term disability benefits for the week of November 17, 2003 will be offset by his salary separation pay such that he will receive 16 weeks of separation pay (from November 17, 2003 through March 5, 2004).

If you are eligible to receive Workers Compensation benefits under state law and STD benefits under this Plan, your STD benefits will be coordinated with any Worker's Compensation benefits you receive. Your Plan benefits will be limited such that the sum of your Plan benefits and your Workers Compensation benefits will not exceed 85% of your Base Salary, unless otherwise required by state Workers Compensation laws

Social Security disability benefits and benefits under the Plan are also coordinated. You receive the maximum benefits available under this Plan and Social Security, but not the total sum of both benefits. Your Plan benefits will be limited such that the sum of your Plan benefits and your Social Security disability benefits will not exceed 100% of your Base Salary, unless otherwise required by Social Security laws.

Benefits provided under state-mandated, non-occupational disability programs in the states of California, New York and New Jersey are also coordinated.

4.02 Will my employee benefits continue while I receive STD benefits?

Benefits offered under any other plan are subject to the laws pertaining to such plans and the terms and conditions of such plans.

4.03 How does California state disability benefits coordinate with benefits provided under the Plan?

Employees living in California who are eligible to participate in the Plan must apply for state benefits through the state EDD (Employment Development Department) at the same time they apply for benefits under the Plan. If the EDD benefit is less than the amount of benefits the employee would receive under the Plan, the employee will receive the difference between the amount of the benefit paid by the EDD and the amount the

employee otherwise would receive under the Plan upon receipt by the Plan of a Notice of Computation (i.e., an EDD check stub) from the employee. You may contact EDD at 1-800-480-3287 or www.edd.ca.gov

4.04 How do New York, New Jersey, or Hawaii state disability benefits coordinate with benefits provided under the Plan?

Employees living in New York or New Jersey who are eligible to participate in the Plan must complete all required The Hartford forms and return such completed forms to the Sprint Disability Management Group.

4.05 If I receive STD benefits from this Plan and payments from another party for lost wages, do I need to reimburse the Plan for the benefits I received under the Plan?

Sometimes, the Plan can recover from other parties the STD benefits it pays to you. Because STD benefits are intended to reimburse you for the wages you lose because of illness or injury, the Plan can “stand in your shoes” and recover from third parties, who caused or contributed to your illness or injury, the benefits you received under the Plan (where permitted by law). If the Plan has this “right of subrogation” you must do anything the Plan reasonably asks you to do to protect these rights and help the Plan recover from the third party.

5. Claims Procedure

5.01 How do you make a claim for STD benefits?

You must apply for STD benefits by completing and signing all forms required by the Plan within fifteen days of your first date of absence qualifying for benefits under the Plan. The forms required by the Plan include:

- a signed application for STD benefits and
- a Health Care Provider Form in which your physician documents your inability to work due to an illness or injury and your estimated return to work date.

The forms required by the Plan can be obtained through:

- Employee Solutions Network (ESN) at 1-800-697-6000
- Attendance Coordinator in PCS contact centers
- Faxback 1-800-697-6000
- Pinpoint <http://ppld.corp.sprint.com/hr/forms/forms.html>
- Connected (PCS Intranet) <http://intranet.sprintspectrum.com>
- Sprint.com <http://www.sprint.com/hr/benefits.html>
- HR Self Serve <http://ppld.corp.sprint.com/hr/hr.html>
- Interactive Voice Response (IVR) Toll Free 1-800-697-6000

The Hartford forms for New York, and New Jersey employees may be requested through the ESN phone number or by contacting The Hartford at 800-741-4306. The Hartford

forms for Hawaii employees may be requested through the ESN phone number or by contacting The Hartford at 808-586-9188.

If you submit all completed, required forms within fifteen days from your first day of absence that qualifies you for STD benefits, your Plan benefits will begin retroactive to the first day after your Waiting Period. If you submit all completed, required forms after fifteen days from your first day of absence that qualifies you for STD benefits, your Plan benefits will begin prospectively on the date the Plan Administrator receives all the completed, required forms under the Plan unless the Plan Administrator determines that the submission was late due to matters beyond your control.

5.02 What if benefits are denied under the Plan?

Within 45 calendar days of a denial letter, you or your authorized representative may provide a reconsideration request to appeal.benefit@mail.sprint.com or in writing to:

Sprint
6500 Sprint Parkway
Overland Park, KS 66251
Attention: Benefit Appeal Group
Mailstop: KSOPHL0302-3A

The Plan Administrator determines if you are covered by the Plan and if you qualify for benefits under the Plan. The Plan Administrator will generally determine claims for benefits under the Plan within 45 days of receipt of a claim. A written denial of a claim under the Plan will give specific reasons for the denial, reference specific Plan provisions on which the denial is based, describe any additional material necessary for you to perfect your claim, and explain the Plan's claim review procedure.

In special circumstances, a response to your claim may take more than 45 days. The Plan administrator may extend this period for up to 30 days if the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you before the end of the 45-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If before the end of this 30-day period, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided the Plan Administrator notifies the claimant, before the end of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

Within 180 days of receiving written notice of claim denial from the Plan Administrator, you or your authorized representative may appeal. This appeal should be in writing and directed to:

Benefit Administrative Committee
Sprint Corporation
6200 Sprint Parkway
Mailstop: KSOPHF0302-3B179
Overland Park, Kansas 66251

In your appeal, include a copy of your denial letter from the Plan Administrator. You should state in your appeal the reasons you believe your claim was improperly denied and submit any additional information, material or comments you consider appropriate.

You will receive a response to your appeal within 45 days. If more time is needed, you will be notified within 45 days after receipt of your request for review. In no event will a decision be made more than 90 days after receipt of your request for review.

You will be informed of the Benefit Administrative Committee's decision. The response will include the specific reasons for the decision as well as specific references to the appropriate Plan provisions on which the decision is based. The decision of the Benefit Administrative Committee is final.

6. ERISA Rights

6.01 As a participant in the Plan, am I entitled to certain rights and protections under ERISA?

As a participant in the Plan you are entitled to certain rights and protections under the ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including 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.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that 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.

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.

6.02 *Can Sprint amend or terminate the Plan?*

While Sprint expects to continue the Plan indefinitely, it has the right to amend or terminate the Plan at any time. Amendments may be made by action of Sprint's Employee Benefits Committee.

This document does not constitute a contract of employment for any particular period of time.

6.03 *Who is the agent for service of legal process for the Plan?*

The agent for service of legal process for the Plan is:

General Counsel
Sprint Corporation
6200 Sprint Parkway
Overland Park, Kansas 66251

Service of legal process may also be made on the Plan Administrator.

6.04 *What is the Plan's fiscal year and number?*

The Plan is on a calendar year and the plan number is 541.

7.0 INFORMATION FOR EMPLOYEES WORKING IN NEW YORK

IMPORTANT INFORMATION

Information for Employees of SPRINT

WHO ARE SUBJECT TO THE NEW YORK DISABILITY BENEFITS LAW

Classes of Employees All Employees

Such Employees may be eligible for the weekly indemnity disability benefits stated below, for disability commencing while employed.

AMOUNT OF WEEKLY BENEFIT

The amount of weekly indemnity to each Employee shall be an amount equal to the greater of (1) 50% of his average weekly earnings under regular employment practice, including overtime or other premium pay when part of regular earnings as of the date of commencement of disability, taken to the next higher multiple of One Dollar if not already a multiple thereof, subject to the statutory maximum or (2) 60% of the basic weekly wage, straight time, subject to the statutory minimum.

DESCRIPTION OF BENEFITS

Under the group policy the weekly indemnity disability benefits are payable commencing with the latest day of disability specified below following the discontinuance of regular remuneration:

- The eighth day of any period of disability caused by accident, except that if the Employee is confined as a resident patient in a legally constituted hospital for three consecutive days during the first week of disability, indemnity shall be paid commencing with the date the Employee is hospital confined,
- The eighth day of any period of disability caused by sickness, except that if the Employee is confined as a resident patient in a legally constituted hospital for three consecutive days during the first week of disability, indemnity shall be paid commencing with the date the Employee is hospital confined,

subject to the exclusions hereinafter contained. Such benefits are payable for not more than 26 weeks during any One period of disability.

EXCLUSIONS

Disability benefits are not payable

- For any period of disability during which an Employee is not under the care of a physician, podiatrist, chiropractor or dentist authorized to render medical care under the workers' compensation law,
- For disabilities caused by injuries self-inflicted, or for disabilities resulting from injuries or sickness sustained in the perpetration of an illegal act,
- For any day of disability during which an Employee performs work for remuneration or profit, or for any day of disability for which the Employee is entitled to receive from his Employer or from a fund to which the Employer has contributed an amount equal to the disability benefits,
- For any period that the Employee is or would be subject to suspension or disqualification under the unemployment insurance law,
- For any period for which benefits are payable to the Employee under the unemployment insurance law of any state or of the United States, or under any workers' compensation act, any other disability benefit or similar law, or under any employer's liability act or under the maritime doctrine of maintenance, wages and cure.

Successive periods of disability caused by the same or related injury, sickness or pregnancy shall be considered as One period of disability only if separated by less than Two weeks of continuous active employment.

The benefits are provided under the subject to the provisions of a group policy issued by The Hartford.

8.0 INFORMATION FOR EMPLOYEES WORKING IN NEW JERSEY

NOTICE

Notice of New Jersey Temporary Disability Benefits

for All Employees of

SPRINT
(called the Employer)

Effective July 1, 1986 this notice outlines the benefits available under a group policy issued by The Hartford to the Employer shown above. The group policy is the Employer's Private Plan of Temporary Disability Benefits as provided by the New Jersey Temporary Disability Benefits Law.

BENEFITS FOR NON-OCCUPATIONAL DISABILITIES ARE AVAILABLE WHILE EMPLOYED AND FOR THE FIRST TWO WEEKS AFTER COVERAGE STOPS IF NOT COVERED BY ANOTHER EMPLOYER.

WEEKLY BENEFIT

The amount of weekly benefit payable to an Employee shall be in accordance with (1) or (2) below, whichever is greater:

- (1) The weekly benefit is 66 2/3% of your average weekly salary or wage taken to the next lower multiple of \$1.00 if not already a multiple of \$1.00. It is subject to the statutory maximum.
- (2) The weekly benefit is 60% of your basic weekly earnings taken to the next lower multiple of \$1.00 if not already a multiple of \$1.00.

If the Employee is entitled to benefit for any period of disability which does not amount to a full week, the benefits will be a multiple of 1/7 of the proper weekly benefit times the number of days in the period of disability.

The result will be taken to the next lower multiple of \$1.00 if not already a multiple of \$1.00.

MAXIMUM BENEFIT DURATION

Benefits are payable up to 26 weeks during any one period of disability.

Benefits are payable starting with the 8th day of disability. If benefits for a period of disability are payable for 3 successive weeks, payment will be made for the first 7 days of disability.

The Employee must be at work for at least 14 days between disabilities from the same cause or condition to have a new period of disability.

PLAN LIMITATIONS

Benefits are not payable for any of the following:

- Any period of disability during which you are not under the care of a physician, an optometrist, a dentist, a podiatrist or a chiropractor. The person must be legally licensed and acting within the range of the practice.
- Any period for which you have received or can receive benefits under any unemployment compensation or similar law, or disability or cash sickness benefit or similar law of the United States or of any state.
- Any period for which you have received or can receive benefits under any workers' compensation law, occupational disease law, or similar law of the United States or of any state. The term "benefits" does not include any benefits you have received or can receive from any previous permanent partial disability or permanent total disability.
- Any period which you would not qualify for Unemployment Compensation Benefits under Section 43:21-5(d) of the Revised Statutes of New Jersey. This will not apply if the disability begins before any period you would not qualify for benefits based on Section 43:21-5(d).
- In excess of an amount which, together with any remuneration the Employee continues to receive from the individual's employer during any period of disability would equal the amount of the individual's regular weekly wages immediately prior to the individual's disability.

EMPLOYEE'S PAYMENT

None.

TO CLAIM BENEFITS

To claim benefits you must give The Hartford written notice of injury or sickness within 30 days after:

- the date of the accident causing the injury.
- The start of disability resulting from the sickness.

Written notice must be given:

- by the Employer, or
- by or in behalf of the covered Employee.

It must be given to The Hartford at its Home Office or to any authorized agent of The Hartford. The notice must contain the Employer's name and enough information to identify the covered Employee.

The Hartford considers this adequate notice for payments of benefits. If it is not possible to give the notice within 30 days, it must be given as soon as possible. The Hartford will not reduce nor deny a claim if the notice is given as soon as reasonably possible.

The Hartford will provide you with a claim form for filing proof of loss. This will occur after written notice has been given to The Hartford. If you do not receive it within 15 days after the notice is given, a claim can be filed without it by sending The Hartford written proof describing the situation.

Valid proof of loss must be given to The Hartford at its Home Office within 30 days after the start of the period for which proof is given. If it is not possible to give the proof within 30 days, it must be given as soon as possible. The Hartford will not reduce nor deny a claim if the proof is given as soon as reasonably possible.

The Hartford has the right to examine any person filing a claim.

The Hartford may examine the person only once each week.

The Weekly Benefit will be paid to you at the end of each week during a period for which The Hartford is liable.

You may not sue on a health claim before 60 days after proof of loss has been given to The Hartford. You may not sue after 3 years from the time proof of loss is required. These conditions will not affect your right of appeal under the New Jersey Temporary Disability Benefits Law.

A person claiming benefits under an approved private plan may not agree with the Employer or The Hartford as to benefits under the approved private plan. Under the provisions of the New Jersey Temporary disability Benefits Law, the person claiming benefits may file a complaint with the Division of Unemployment and Disability Insurance and Department of Labor.

The complaint must be filed One year after the start of the period for which benefits are claimed. The Division requires that an appeal be submitted in writing to the:

Disability Insurance Service
Bureau of Private Plans
Labor Building
John Fitch Plaza
CN 387
Trenton, NJ 08625

THE BENEFITS DESCRIBED HEREIN ARE SUBJECT TO THE PROVISIONS OF THE POLICY AND CONFORM IN ALL RESPECT WITH THE NEW JERSEY TEMPORARY DISABILITY BENEFITS LAW, AND WILL NEVER BE LESS LIBERAL THAN THE BENEFITS OTHERWISE PROVIDED BY SAID LAW.

THIS NOTICE SUPERSEDES ALL NOTICES PREVIOUSLY ISSUED.