Group Critical Illness and Cancer Plan

Prepared Exclusively For
Sacred Heart University, Incorporated

Critical Illness Plus with Cancer Low Plan

What Your Plan Covers and How Benefits are Paid

Aetna Life Insurance Company
Certificate

This Certificate is part of the Group Critical Illness and Cancer Policy between Aetna Life Insurance Company and the Policyholder

Critical Illness and Cancer Certificate

Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

The words which appear in **bold** type are defined in the Definitions section of this Certificate.

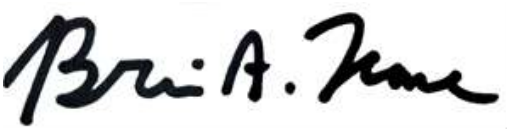
This Certificate explains the insurance benefits issued to the **policyholder** named in the Schedule of Benefits. **We** agree to pay the benefits to each **insured person** in accordance with the terms of the Policy.

The Policy under which this Certificate is issued may be amended or cancelled at any time as stated in its provisions. Only an officer of Aetna Life Insurance Company may approve a change and it must be done in writing. Such action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

THIS CERTIFICATE IS NOT MEDICARE SUPPLEMENT COVERAGE. IF **YOU** ARE ELIGIBLE FOR MEDICARE, REVIEW "THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE", WHICH IS AVAILABLE FROM **US**.

This Certificate replaces any previous certificate(s) issued to the **employee** under the Policy.

Signed for Aetna Life Insurance Company.
(A Stock Company)



Brian A. Kane
President

NOTICE OF 30 DAY RIGHT TO EXAMINE CERTIFICATE

You have 30 days from the date of delivery of this Certificate to examine it. If you are not satisfied for any reason, the Certificate may be returned within 30 days to us at our home office or to the writing agent. We will refund the premium paid and the Certificate will be void from its beginning.

CAUTION! This Certificate PROVIDES LIMITED COVERAGE. IT IS NOT A MAJOR MEDICAL CERTIFICATE. Read it carefully. It only pays benefits for diagnosis of critical illness and cancer.

The Policy is a non-participating Policy and does not share in the company's surplus.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This plan provides limited benefits. The benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

This plan does not count as minimum essential coverage under the Affordable Care Act.

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Eligibility

An employee of the **employer** is in an eligible class if he or she is a regular, **actively-at-work** employee of the **employer**, according to criteria the **employer** sets to define the eligible class for coverage under this plan. Such criteria are based solely upon the conditions related to his or her employment. **We** will rely upon the representation of the **employer** as to eligibility for coverage under this plan and as to any fact concerning such eligibility. Eligibility for insurance may be modified to accommodate the **employer's** common practices.

To be covered by this plan, the following requirements must be met:

- The eligible employee will need to be in an eligible class, as defined by the **employer**;
- The eligible employee has reached his or her eligibility date; and
- The eligible employee has completed the **employer's** eligibility waiting period or probationary period.

Dependents

Your dependents can be covered under **your** plan. **You** may enroll the following dependents:

- **Your** legal spouse.
- **Your** dependent children.

We will rely upon **your employer** to determine whether or not a person meets the definition of a dependent for coverage under this plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

To be eligible, a dependent child must be:

- Under 26 years of age; or
- Over the limiting age shown above who is not able to earn his or her own living because of mental or physical handicap which started prior to the date he or she reaches the limiting ages and who is chiefly dependent on **you** for support and maintenance. **We** require proof of such incapacity no later than 31 days after the date the child's coverage would otherwise have terminated due to the limiting age. **We** have the right to require proof of the continuation of the incapacity, at **our** expense, as often as needed, but not more often than once each two years from the date the child reached the limiting age.

An eligible dependent child includes:

- **Your** biological children;
- **Your** stepchildren;
- **Your** legally adopted children and children placed with you for adoption;
- **Your** children for whom you are required to provide coverage under a medical support order;
- **Your** foster children; and
- Any other child who lives with **you** in a parent-child relationship.

Important Reminder
Keep in mind that an insured dependent child cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Enrollment Procedure

An eligible employee will be provided with plan benefit and enrollment information when he or she first becomes eligible to enroll. To complete the enrollment process, all requested information for the eligible employee and his or her eligible dependents must be provided. Eligible employees will also need to agree to make required premium payments. The **employer** will determine the amount of required premium contribution, which will need to be agreed to before enrollment. The **employer** will advise of the required amount of premium contribution. Premiums are subject to change.

Enrollment will need to be made within 31 days of the eligibility date. If an eligible employee misses the enrollment period, he or she will not be able to participate in this plan until the next annual enrollment period. If an eligible employee does not enroll for coverage when he or she first becomes eligible, but wishes to do so later, the **employer** will provide the information on when and how enrollment can be done.

Newborns are automatically covered for 31 days after live birth provided payment of premium is received by **us**. To continue coverage after 31 days, **you** will need to complete an Enrollment/Change Request form and return it to **your employer** within the 31-day enrollment period.

Effective Date of Coverage

If an eligible employee has met all the eligibility requirements, his or her coverage takes effect on the later of:

- The date his or her required premium payment is received by **us**; or
- Such other date as set forth in criteria established between the **employer** and **us**.

Important Note:

Actively-at-work rule:
If an eligible employee is not **actively-at-work** due to **sickness, accidental injury** or leave of absence, the coverage will not take effect until after he or she has returned to work and have completed one regularly scheduled work day; week.

This means that he or she must be **available to work** on the effective date of coverage in order to be eligible for coverage under this plan. He or she will be considered **available to work** if he or she meets the eligibility requirements, if any, specified by the **employer** to govern eligibility for coverage under this plan, or if he or she has accrued hourly fringe benefit contributions.

This rule also applies to an increase in **your** coverage.

Your dependent's coverage takes effect on the same day that **your** coverage becomes effective, if **you** have enrolled them in this plan by then.

Note: New dependents need to be reported to **us** within 31 days because they may affect **your** premium payment. If **you** do not report a new dependent within 31 days of his or her eligibility date, then that dependent will not be able to participate in the plan until **your employer's** next annual enrollment period.

Adopted Children and Medical Support Orders:

1. An adopted child who meets the definition of dependent as of the date the child is adopted or placed for adoption, may be enrolled provided:

   - Such adoption or placement takes effect after the date **your** coverage becomes effective; and
   - **You** make written request for coverage for the child within 31 days of the date the child is adopted or placed with **you** for adoption because they may affect **your** premium payment. If **you** do not report the child within 31 days of his or her eligibility date, that child will not be able to participate in this plan until **your employer's** next annual enrollment period, if any.

   As used here, "placed for adoption" means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

2. A child for whom **you** are required to provide health coverage as the result of a qualified medical child support order and who meets the definition of dependent, may be enrolled provided:

   - The support order was issued on or after the date **your** coverage becomes effective; and
   - **You** make written request for coverage for the child within 31 days of the date of the support order because they may affect **your** premium payment. If **you** do not report the child within 31 days of his or her eligibility date, that child will not be able to participate in this plan until **your employer's** next annual enrollment period, if any.

   If **you** are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Coverage for the child will become effective on the date specified by **your employer**.

Premium Provisions

We require that **you** make premium contributions.

If payments are made through a payroll deduction with **your employer**, **your employer** will forward **your** payment to **us**.

Our Right to Change Premium Rates. We have the right to change **our** premium rates. **We** will give the **policyholder** at least 31 days prior written notice of any change.

Refund of Unearned Premium. If coverage under this Certificate for an **insured person** terminates for any reason, **we** will promptly refund any unearned premium with respect to such **insured person**.

Schedule of Benefits

Policyholder:	**Sacred Heart University, Incorporated**
Group Policy No.:	GP-802333
Issue Date:	September 10, 2019
Group Policy Effective Date:	January 1, 2024
Plan Year:	January 1st to December 31st

Employee Face Amount	$10,000
Insured Spouse/ Face Amount	50% of the **employee** Face Amount
Insured Children Face Amount	50% of the **employee** Face Amount

Critical Illness Benefit	Percentage of Face Amount
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Condition Requiring Bypass Surgery	25%
Major Organ Failure	100%
End-Stage Renal Failure	100%
Coma	100%
Paralysis	100%
Occupational Human Immunodeficiency Virus (HIV)	100%
Benign Brain Tumor	100%
Loss of Sight (Blindness)	100%
Loss of Hearing	100%
Loss of Speech	100%
Third Degree Burns	100%
Alzheimer's Disease	25%
Parkinson's Disease	25%
Lupus	25%
Multiple Sclerosis	25%
Muscular Dystrophy	25%

Cancer Benefit	Percentage of Face Amount/Benefit Amount
Cancer (Invasive) Carcinoma in Situ	100% 25%
Skin Cancer Maximum	$1,000 once per **insured person's** lifetime

Additional Benefits	Benefit Amount
Health Screening Benefit Maximum per **Plan Year**	$50 1

Benefits

We reserve the right to request that a **physician** of **our** choice review any **diagnosis** in the event of a dispute or disagreement regarding the appropriateness or correctness of a **diagnosis**. **We** reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed **diagnosis**. **We** will pay for any such requested examination or review.

Critical Illness Benefit

We will pay the applicable benefit shown on the Schedule of Benefits if an **insured person** is **diagnosed** with a **critical illness**, and:

- The **date of diagnosis** must occur while coverage for the **insured person** is in force; and
- The **critical illness** is not excluded by name or specific description in this Certificate.

If the **date of diagnosis** of two or more **critical illnesses** is the same day, **we** will pay only the **diagnosis** with the highest benefit.

If an **insured person** has been initially **diagnosed** with and received a benefit for a **critical illness**, and then the **insured person** is **diagnosed** again with the same **critical illness** (a recurrence), a benefit may or may not be payable for the recurrence. See the Recurrence Critical Illness Diagnosis Benefit for more detail.

If an **insured person** has been **diagnosed** with and received a benefit for a **critical illness** and is subsequently **diagnosed** with a different **critical illness**, a benefit may or may not be payable for the subsequent **diagnosis**. See the Subsequent Critical Illness Diagnosis Benefit for more detail.

Cancer Benefit

We will pay the applicable Cancer Benefit when an **insured person** is initially **diagnosed** as having **cancer (invasive)**, **carcinoma in situ** or **skin cancer** if:

- The **date of diagnosis for cancer (invasive)**, **carcinoma in situ or skin cancer** must occur while coverage for the **insured person** is in force; and
- The **cancer (invasive)**, **carcinoma in situ** or **skin cancer** is not excluded by name or specific description in this Certificate.

Cancer (invasive), **carcinoma in situ** or **skin cancer** must be **diagnosed** by either **pathological diagnosis** or **clinical diagnosis**. In addition to the required **pathological diagnosis** or **clinical diagnosis**, **we** may require additional information from the attending **physician** and **hospital**.

If the required **pathological diagnosis** or **clinical diagnosis** for **cancer (invasive)**, **carcinoma in situ** or **skin cancer** can only be made post-mortem, the Cancer Benefit for Cancer (invasive), Carcinoma in Situ or Skin Cancer is payable.

If the **date of diagnosis** of two or more **cancer diagnoses** is the same day, **we** will pay only the **diagnosis** with the highest benefit.

If an **insured person** has been initially **diagnosed** with and received a benefit for **cancer (invasive)** and is subsequently **diagnosed** with **cancer (invasive)** again, a benefit may or may not be payable for the recurrence. See the Recurrence Cancer (invasive) Diagnosis Benefit for more detail.

If an **insured person** has been initially **diagnosed** with and received a benefit for **carcinoma in situ** and is subsequently **diagnosed** with **carcinoma in situ** again, a benefit may or may not be payable for the recurrence. See the Recurrence Carcinoma in Situ Diagnosis Benefit for more detail.

Additional Benefits

Health Screening Benefit

We will pay the Health Screening Benefit shown on the Schedule of Benefits if an **insured person** receives any of the below named Covered Health Screenings, and:

- A charge must be incurred for the **care** of an **insured person** due to the screening.
- The date of service must occur while coverage for the **insured person** is in force.

Covered Health Screenings:

Lipoprotein profile (serum plus HDL, LDL and triglycerides)	Skin cancer screening
Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)	Serum protein electrophoresis (blood test for myeloma)
Fasting blood glucose test	Prostate Specific Antigen (PSA) Test
Carotid Doppler Ultrasound	Flexible sigmoidoscopy
Electrocardiogram (EKG, ECG)	Digital rectal exams (DRE)
Echocardiogram (ECHO)	Hemoccult stool analysis
Chest x-ray (CXR)	Colonoscopy
Thermography	Virtual colonoscopy
Ultrasound screening for abdominal aortic aneurysms	Carcinoembryonic Antigen (CEA)
Bone marrow screening	Cancer Antigen (CA) Test 15-3 (breast cancer)
Adult and child immunizations	Mammography
HPV vaccine (Human Papillomavirus)	Breast Ultrasound
Bone mass density measurement (DEXA, DXA)	Cancer Antigen (CA) Test 125 (ovarian cancer)
	Pap smears
	Cytological Screening
	ThinPrep Pap Test

Recurrence and Subsequent Diagnosis Benefit

Recurrence Critical Illness Diagnosis Benefit

If an **insured person** has been initially **diagnosed** with and received a benefit for a **critical illness**, and then the **insured person** is **diagnosed** again with the *same* **critical illness** (a recurrence), **we** will pay 50% of the applicable Critical Illness Benefit as shown on the Schedule of Benefits for the recurring **critical illness diagnosed**, if:

- The **date of diagnosis** of the recurring **critical illness** is more than 180 days after the previous **date of diagnosis** for the same **critical illness** for which a benefit was paid;
- The **date of diagnosis** for the recurrence is while coverage for the **insured person** is in force; and
- The reoccurring **critical illness** is not excluded by name or specific description in this Certificate.

Subsequent Critical Illness Diagnosis Benefit

If an **insured person** has been **diagnosed** with and received a benefit for a **critical illness** and is subsequently **diagnosed** with a different **critical illness**, **we** will pay 100% of the applicable Critical Illness Benefit as shown on the Schedule of Benefits for the **critical illness** subsequently **diagnosed**, if:

- The subsequent **date of diagnosis** is while coverage for the **insured person** is in force; and
- The subsequent **critical illness** is not excluded by name or specific description in this Certificate.

Recurrence Cancer (invasive) Diagnosis Benefit

If an **insured person** has been initially **diagnosed** with and received a benefit for **cancer (invasive)** and is subsequently **diagnosed** with any kind of **cancer (invasive)** again, **we** will pay 50% of the Cancer Benefit for Cancer (invasive) as shown on the Schedule of Benefits for the **cancer (invasive) diagnosed**, if:

- The **date of diagnosis for cancer (invasive)** of the subsequent **cancer (invasive) diagnosis** is more than 180 days after the previous **date of diagnosis for cancer (invasive)** for which a benefit was paid;
- The **insured person** has not received treatment for the initial **cancer (invasive)** for which a benefit was paid during the 180 days between the **dates of diagnosis for cancer (invasive)**. As used here, "treatment" does not include **maintenance drug therapy** or routine follow-up visits to the **insured person's physician** to confirm the initial **cancer (invasive)** has not returned;
- The subsequent **date of diagnosis for cancer (invasive)** is while coverage for the **insured person** is in force; and
- The subsequent **cancer (invasive)** is not excluded by name or specific description in this Certificate.

Recurrence Carcinoma in Situ Diagnosis Benefit

If an **insured person** has been initially **diagnosed** with and received a benefit for **carcinoma in situ** and is subsequently **diagnosed** with any kind of **carcinoma in situ** again, **we** will pay 50% of the Cancer Benefit for Carcinoma in Situ as shown on the Schedule of Benefits for the **carcinoma in situ diagnosed**, if:

- The **date of diagnosis for carcinoma in situ** of the subsequent **carcinoma in situ diagnosis** is more than 180 days after the previous **date of diagnosis for carcinoma in situ** for which a benefit was paid;
- The **insured person** has not received treatment for the initial **carcinoma in situ** for which a benefit was paid during the 180 days between the **dates of diagnosis for carcinoma in situ**. As used here, "treatment" does not include **maintenance drug therapy** or routine follow-up visits to the **insured person's physician** to confirm the initial **carcinoma in situ** has not returned;
- The subsequent **date of diagnosis for carcinoma in situ** is while coverage for the **insured person** is in force; and
- The subsequent **carcinoma in situ** is not excluded by name or specific description in this Certificate.

Exclusions

Exclusions: Benefits under the Policy will not be payable for any **critical illness, cancer (invasive), carcinoma in situ or skin cancer** that is **diagnosed** or for which **care** was received outside the United States and its territories, or for any loss caused in whole or in part by or resulting in whole or part from the following:

1. Suicide or attempt at suicide, intentional self-inflicted injury or **sickness**, any attempt at intentional self-inflicted injury, injury caused by a self-inflicted act or **sickness**, while sane or insane; except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
2. Engaging in a felony for which the **insured person** has been convicted under state or federal law;
3. Any act of war, whether declared or not, or voluntary participation in a rebellion or civil insurrection.

Also, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his **physician** for the insured.

Note – If any **critical illness**, **cancer (invasive), carcinoma in situ** or **skin cancer** is **diagnosed** outside the country and is subsequently confirmed through a **diagnosis** in the United States, including its territories, a benefit is payable for the **critical illness**, **cancer (invasive), carcinoma in situ** or **skin cancer** diagnosed.

General Provisions

Independent, Non-Coordinated Benefits. Each benefit under the Policy is independent of and is not coordinated with the benefits, exclusions or any other provision of any other health insurance coverage or health plan. Each benefit under the Policy is payable with respect to any event without regard to whether benefits are provided with respect to the same event under any other health insurance coverage or health plan. Benefits payable under the Policy will not be reduced on account of any other health insurance coverage or health plan.

Notice of Claim. The **insured person** must give **us** written notice of claim. It must be given within 20 days after a covered loss occurs or starts, or as soon as reasonably possible. The notice must be given by the **insured person** or the **insured person's** representative. Such notice should include the **insured person's** name and Policy number. Written notice should be mailed to **us** at the **company** address appearing on the face page of this Certificate or to any authorized agent.

Claim Forms. When **we** receive notice of claim, **we** will provide the **insured person** forms for filing proof of loss. If **we** do not provide them within 15 days, the **insured person** can meet the proof of loss requirement by giving **us** a written statement of what happened. This statement should include the type and extent of the loss incurred. **We** must receive this statement within the time given for filing proof of loss.

Proof of Loss. If the Policy provides for periodic payment for a continuing loss, written proof of loss must be given to **us** within 90 days after the end of each period for which **we** are liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, **we** will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

Time of Payment of Claims. We will pay benefits promptly upon receipt of due written proof of loss for benefits provided under the Policy. However, a benefit that is payable by periodic payments, subject to due written proof of loss, will be paid monthly. Any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of due written proof.

Payment of Claims. Benefits will be paid to the **insured person**. Benefits unpaid at death may be paid, at **our** option, either to the **insured person's** beneficiary or estate. If benefits are payable to the **insured person's** estate or a beneficiary who cannot execute a valid release, **we** can pay benefits up to $1,000 to someone related to the **insured person** or the **insured person's** beneficiary by blood or marriage whom **we** consider to be entitled to the benefits. **We** will be discharged to the extent of any such payment made in good faith.

Complaints. If the **insured person** is dissatisfied with the service received from this plan, the **insured person** must call or write Member Services within 30 calendar days of the incident. The complaint must include a detailed description of the matter and include copies of any records or documents that are relevant to the matter. **We** will review the information and provide a written response to the **insured person** within 30 calendar days of the receipt of the **complaint**, unless more information is needed and it cannot be obtained within this period. The notice of the decision will explain what the **insured person** needs to do to seek an additional review.

Assignments of Your Coverage. Coverage may not be assigned. An assignment is the transfer of **your** rights under this Certificate to a person **you** name.

Overpayments. We have the right to recover any overpayments due to fraud and any error **we** make in processing a claim. **You** must reimburse **us** in full. **We** will determine the method by which the repayment is to be made.

Unpaid Premium. Any unpaid premium due for an **insured person's** coverage under the Policy may be recovered by **us** by offsetting against amounts otherwise payable under the Policy.

Change of Beneficiary. Unless the **insured person** makes an irrecoverable designation of beneficiary, the right to change a beneficiary is reserved to the **insured person** and the consent of the beneficiary or beneficiaries will not be requisite to assignment of the Policy or to change of beneficiary or beneficiaries or to any changes in the Policy. A change of beneficiary will not have a bearing on any payment **we** made before **we** receive the change.

Physical Examination and Autopsy. We, at **our** expense, may have the **insured person** examined when and as often as **we** may reasonably require while a claim is pending and to have an autopsy performed after an **insured person's** death as allowed by law.

Legal Actions. No legal action may be brought to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be given.

Workers' Compensation. The Policy is not a Workers' Compensation policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

Conformity With State Statutes. Any provision of this Certificate which, on or after the Group Policy Effective Date, is in conflict with the statutes of the state in which **you** reside on such date, is hereby amended to conform to the minimum requirements of such state.

Appeal Procedure

If **we** give notice of an **adverse benefit determination**, the **insured person** may submit an **appeal**. This plan provides for one level of **appeal**.

The **insured person** has 90 calendar days after the receipt of notice of an **adverse benefit determination** to request an **appeal** orally or in writing. The **appeal** must include:

- The **insured person's** name.
- The **policyholder's** name.
- A copy of **our** notice of an **adverse benefit determination**.
- The reasons for making the **appeal**.
- Any other information the **insured person** would like to have considered.

The **insured person** may choose to have another person (an authorized representative) make the **appeal** on their behalf. The **insured person** must provide written consent to **us**.

A review of an **appeal** of an **adverse benefit determination** shall be provided by **our** personnel. They shall not have been involved in making the **adverse benefit determination**.

We shall issue a decision within 60 calendar days of receipt of the request for an **appeal**.

Exhaustion of Process. The **insured person** is encouraged, but not required, to exhaust the applicable Appeal Procedure before:

- Contacting the Connecticut Insurance Department to request an investigation of a **complaint** or **appeal**; or
- Filing a complaint or **appeal** with the Connecticut Insurance Department; or
- Establishing any:

    - litigation;
    - arbitration; or
    - administrative proceeding;

regarding an alleged breach of the policy terms by **us** or any matter within the scope of the Appeal Procedure.

Termination of Coverage

Termination of Coverage. Your coverage under this Certificate will end, subject to the Portability Provision, on the earliest of the following dates:

- The date **you** cease to be a member of an eligible class;
- The date the eligible class to which the **you** are a member is no longer an eligible class for coverage under the Policy;
- The date **we** receive your written request for termination of coverage;
- The payment due date, if any required premium has not been paid by the end of the grace period;
- The date of **your** death;
- The date the Policy is cancelled or terminated.

Termination of coverage under the Policy will not affect a claim that existed on the date of termination.

Termination of Insured Dependents. An **insured dependent's** coverage under this Certificate will end, subject to the Portability Provision, on the earliest of the following dates:

- The date **your** coverage terminates;
- The date the Policy terminates coverage for all dependents;
- The date an **insured dependent** becomes covered as an employee;
- The date an **insured dependent** is no longer eligible as a dependents;

Portability Provision

If **your** coverage under the Policy terminates while the Policy remains in force, **we** will provide portability coverage. Such coverage will be available to **you** and any of **your insured dependents**.

You must complete the Portability Coverage Election Form and return it to **us** along with payment the first premium for the portability coverage not later than 30 calendar days after **your** coverage under the Policy terminates. Portability coverage will be effective on the day after benefits under the Policy terminates.

The benefits, terms and conditions of portability coverage will be the same as those provided under the Policy on the date **your** coverage terminated. Any changes made to the Policy after **you** are covered under the Portability Provision will not apply to **you** unless required by law.

The initial premium rates will be based on the premium rates in effect at the time **you** apply for portability coverage. **You** must also pay any portion of the premium previously paid by **your employer** for the coverage.

A grace period of 10 days after the premium due date will be allowed for the payment of each premium. **We** will not pay benefits under this Certificate in the absence of payment of current premium, subject to this grace period.

Portability coverage will end on the earliest of the following dates:

- The date the Policy terminates;
- The date of the **insured person's** death;
- The date **you** attain age 80;
- The end of the portability grace period following the date the **insured person** fails to pay the required premium;
- The end of the month on or following the date **you** are again covered under the Policy;
- The date coverage under this Portability Provision is cancelled or terminated by **us** for any reason upon 31 days advanced notice;
- The date **your** class of coverage is terminated;
- With respect to any **insured dependents**:

    - The date **your** coverage terminates;
    - The date **you** and **your insured spouse** divorce;
    - The date **your insured dependent** ceases to be an eligible dependent under the Policy.

An **insured child** whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, or he or she is otherwise eligible.

Once portability coverage is cancelled or terminated, it cannot be reinstated.

You and any of **your insured dependents** may not be covered under both this Portability Provision and the Conversion Privilege, explained below, at the same time.

Conversion Privilege

If **your** coverage under the Policy terminates while the Policy remains in force, or if the Policy terminates, and as a result your coverage under this Certificate ends, **you** and any of **your insured dependents** may convert to an individual policy. To convert to an individual policy, **you** must submit a Conversion Policy Application and the required premium must be received by **us** within thirty-one (31) days after **your** coverage under the Policy terminates. If a written application is not made within thirty-one (31) days following the termination of coverage under this Policy, a conversion policy will not be available.

An Evidence of Insurability Statement will not be required. The conversion policy will provide similar benefits as coverage under this Certificate.
The conversion policy will take effect at 12:01 a.m. local time, at **your** or **your insured dependents** residence, on the day after coverage under this Certificate ends.

You and any of **your insured dependents** may not be covered under both this Conversion Privilege and the Portability Provision, explained above, at the same time.
An Evidence of Insurability Statement will not be required. The conversion policy will provide similar benefits as coverage under this Certificate.

Critical Illness Definitions

In this section, **insured persons** will find the definitions for the words and phrases that appear in **bold type** throughout the text of the Certificate/Policy and any attached Riders.

Accident means an unforeseen event, which occurs on or after the effective date of coverage for the **insured person** and while this Certificate is in force, that is the direct cause of an **accidental injury** to an **insured person**.

Accidental injury means bodily injury to an **insured person** that is directly caused by an **accident** and is the direct cause of an injury or loss sustained on or after the **insured person's** effective date of coverage and while this Certificate is in force, which is independent of **sickness**, disease or bodily infirmity and not excluded under the Policy.

Active-at-work; **actively-at-work**; **active work**; **available-to-work**
You will be considered to be **active-at-work**, **actively-at-work**, **available-to-work** or performing **active work** if, **you** are **available to work** or performing the regular duties of **your** job.

Adverse benefit determination (decision) means a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit. Such **adverse benefit determination** may be based on the **insured person's** eligibility for coverage or coverage determinations, including plan exclusions.

Alzheimer's disease means a **diagnosis** of the disease by a psychiatrist or neurologist that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST). The **insured person** must have permanent clinical loss of the ability to do all of the following: remember, reason and perceive; and understand, express and give effect to ideas. No other dementing organic brain disorders or psychiatric illnesses shall meet the definition of **Alzheimer's disease**.

Appeal means an oral or written request to **us** to reconsider an **adverse benefit determination**.

Benign brain tumor means being **diagnosed** with a brain tumor that is not cancerous. **Benign brain tumor** does not include:

- Tumors of the skull;
- Pituitary adenomas; or
- Germanomas.

Care means medical treatment or attention received in an **emergency room**, **hospital** or by a **physician** or other licensed health care provider.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance.

Complaint means any oral or written expression of dissatisfaction about quality of care or the operation of this plan.

Coronary artery condition requiring bypass surgery means being **diagnosed** with narrowing or blockage of one or more coronary arteries, for which surgery is required and is performed in which the patient is placed on a cardiac pulmonary bypass machine and bypass graft(s) are performed. This excludes conditions corrected by procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Critical illness means the **insured person** is **diagnosed** as having a **heart attack (myocardial infarction)**, **stroke**, **Coronary artery condition requiring bypass surgery**, **major organ failure**, **end stage renal failure**, as being in a **coma**, as having **paralysis**, **occupational HIV**, a **benign brain tumor**, **loss of sight (blindness)**, **loss of hearing**, **loss of speech**, **third degree burns**, **Alzheimer's disease**, **Parkinson's disease**, **lupus**, **multiple sclerosis**, and **muscular dystrophy**.

Date of diagnosis means the date the **insured person** receives a **diagnosis** for:

1. **Heart attack (myocardial infarction)**, the date a **physician** confirms that a **heart attack** has occurred;
2. **Stroke**, the date a **physician** confirms a **stroke** occurred;
3. **Coronary artery condition requiring bypass surgery**, the date the cardiologist performs coronary artery bypass surgery.
4. **Major organ failure**, the date that the **insured person** is placed on the United Network of Organ Sharing (UNOS) list for transplantation;
5. **End stage renal failure**, the date that regular hemodialysis or peritoneal dialysis begins;
6. **Coma**, the date a **physician** confirms a **coma** has occurred;
7. **Paralysis**, the date the doctor confirms the **paralysis** continued for a period of 60 consecutive days;
8. **Occupational HIV**, the date of a positive antibody test for HIV subsequent to a prior negative test for the same condition with a lapse of between 180 days between the two tests;
9. **Benign brain tumor** means the date a **physician** determines a benign brain tumor is present.
10. **Loss of sight (blindness)**, the date a **physician** confirms the **loss of sight (blindness)** has continued for a period of 90 consecutive days;
11. **Loss of hearing**, the date a **physician** confirms the **loss of hearing** has continued for a period of 90 consecutive days;
12. **Loss of speech**, the date the **physician** confirms the **loss of speech** has continued for a period of 90 consecutive days;
13. **Third degree burns**, the date a **physician diagnoses** the **insured person** as having a **third-degree burn**;
14. **Alzheimer's disease**, the date a **physician diagnoses** the **insured person** as having **Alzheimer's disease**;
15. **Parkinson's disease**, the date a **physician diagnoses** the **insured person** as having **Parkinson's disease**;
16. **Lupus**, the date a **physician diagnoses** the **insured person** as having **lupus**;
17. **Multiple sclerosis**, the date a **physician diagnoses** the **insured person** as having **multiple sclerosis**;
18. **Muscular dystrophy**, the date a **physician diagnoses** the **insured person** as having **muscular dystrophy**.

Diagnosis/diagnosed means a **physician**, specializing in a particular field of medicine, where applicable, has definitively identified a **sickness** or irregularity in an **insured person**. Such **diagnosis** must:

- Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the **insured person's** medical records; and
- Meet all diagnostic requirements stated in the Policy for the particular **critical illness**, **cancer (invasive)**, **carcinoma in situ**, or **skin cancer** being **diagnosed**.

Emergency room means a specified area within a **hospital** that is designated for the emergency **care** of **accidental injuries**. This area must:

- Be staffed and equipped to handle trauma;
- Be supervised and provide **care** by a **physician**;
- Provide **care** 7 days per week, 24 hours per day.

Employee means a person listed as an employee on the books of the **employer** and who is enrolled under the Policy/Certificate.

Employer means the **policyholder**.

End-stage renal failure means irreversible failure of both kidneys requiring an **insured person** to undergo regular hemodialysis or peritoneal dialysis at least weekly.

Heart attack means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. **Diagnosis** of a **heart attack** requires all three of the following criteria:

- Clinical picture of myocardial infarction;
- New electrocardiogram (EKG or ECG) findings consistent with myocardial infarction; and
- Elevation of cardiac enzymes above standard laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used).

Confirming diagnostic data from one or more of the following test results, or other diagnostic tests as may be determined, may also be required in support of a **diagnosis** of myocardial infarction:

- Thallium;
- PECT;
- Stress echo results; or
- Cardiac catheterization.

Hospital means an institution that:

- Is operated pursuant to law and is licensed as a **hospital** by the responsible state agency;
- Is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the **hospital** on a prearranged basis and under the supervision of a staff of duly licensed **physicians**, medical, diagnostic and major surgical facilities for the **care** of sick or injured persons on an inpatient basis for which a charge is made;
- Provides 24-hour nursing services by or under the supervision of registered graduate professional nurses (RNs); and
- Connecticut's mobile field **hospital**.

Hospital does NOT mean or include:

- Convalescent, assisted living, extended care, hospice, rest or nursing facilities;
- Facilities primarily affording custodial, educational or rehabilitative **care** or facilities primarily for the aged or for substance abusers; or
- A private monitored room.

Immediate family member means a person who is related to the **insured person** in any of the following ways: spouse, child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law), parents (including stepparent, mother-in-law and father-in-law), and brother or sister (including stepbrother, stepsister, brother-in-law or sister-in-law).

Insured child(ren) means **your** dependent child(ren) who are enrolled for coverage under the Policy/Certificate.

Insured dependents means **your insured spouse** and **insured child(ren)**.

Insured person means **you** and any **insured dependents**.

Insured spouse means **your** spouse who is enrolled for coverage under the Policy/Certificate.

Loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device.

Loss of sight (blindness) means total and irrecoverable loss of sight in both eyes.

Loss of speech means loss of one's ability to communicate through speech, such that speech cannot be corrected to any functional degree by any procedure, aid or device.

Lupus means a **diagnosis** by a **physician** of systemic lupus erythematosus, indicated by at least four of the following:

- Malar rash: butterfly-shaped rash across cheeks and nose.
- Discoid (skin) rash: raised red patches.
- Photosensitivity: skin rash as result of unusual reaction to sunlight.
- Ulcers of the nose or mouth.
- Arthritis (nonerosive) in two or more joints, along with tenderness, swelling, or effusion.
- Inflammation of the lining around the heart (pericarditis) and/or lungs (pleuritis).
- Seizures and/or psychosis.
- Excessive protein in the urine, or cellular casts in the urine.
- Hemolytic anemia, low white blood cell count, or low platelet count.
- Antibodies to double stranded DNA, antibodies to Sm, or antibodies to phospholipids such as cardiolipin.
- Antinuclear antibodies (ANA): a positive test in the absence of drugs known to induce positive results.

Lupus does not include discoid lupus or drug-induced lupus.

Major organ failure means **diagnosis** of **major organ failure** of the heart, kidney, liver, lung, or pancreas resulting in the **insured person** being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

Multiple sclerosis (MS) means a **diagnosis** by a **physician** of at least one of the following:

- Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- Well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Muscular dystrophy means a **diagnosis** by a **physician** of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

Occupational human immunodeficiency virus (HIV) means the presence of HIV or antibodies to the HIV virus which:

- Is caused by an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid; and
- Occurs while the **insured person** was following his or her normal occupational duties and is reported by the **insured person** in accordance with the established occupational procedures for such accidents.

The **insured person** must have undergone a blood test within 5 days of the accident that indicates the absence of HIV or antibodies to the HIV virus and the accident follow-up must have included a further blood test within 180 days that indicated the presence of HIV or antibodies to the HIV virus.

Parkinson's disease means a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor, rigidity, bradykinesia and gait disturbance diagnosed by a **physician** trained in the **diagnosis** of **Parkinson's disease**.

Paralysis means injury resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the **insured person's** attending **physician**.

Physician means a licensed medical provider, other than the **insured person**, an **immediate family member** or anyone living at the **insured person's** residence, who acts within the scope of his or her license and provides necessary **care**.

Plan year means the period during which benefit maximums accumulate. Each new **plan year**, these maximums reset.

Policyholder means the **employer** who holds the Master Policy.

Sickness means a disease, bodily infirmity, illness, infection or any other physical condition that affects the **insured person** and is wholly independent of an **accident**.

Stroke means an acute or sub-acute cerebral vascular incident producing permanent, neurological impairment and resulting in **paralysis** or other measurable objective neurological defect persisting for at least 30 days. **Diagnosis** of a **stroke** must be evidenced by a clinical picture of permanent neurological damage provided from a computed tomography (CT or CAT) scan and/or a magnetic resonance imaging (MRI), or such other diagnostic tests as may be required. **Stroke** does not include transient, ischemic attacks and attacks of vertebrobasilar ischemia.

Third degree burns, also called full-thickness burns, means an area of tissue damage in which there is destruction of the entire epidermis (outer layer of skin) and the dermal (second layer of skin) that covers more than 10% of total body surface and that is caused by heat, electricity, radiation or chemicals.

You, your or **yourself** means the **employee**.

We, **company**, **us** or **our** means Aetna Life Insurance Company.

Cancer Definitions

Cancer (invasive) means a disease that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.

The following are not **cancer (invasive)** for purposes of this Certificate:

- Pre-malignant conditions or conditions with malignant potential;
- **Carcinoma in situ**;
- **Skin cancer**.

Carcinoma in situ means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. **Skin cancer** will not be considered **carcinoma in situ** for purposes of this Certificate.

Clinical diagnosis is based on the study of symptoms. Also:

- A **pathological diagnosis** cannot be made because it is medically inappropriate or life-threatening;
- There must be medical evidence supporting the **diagnosis**; and
- The **insured person** must be receiving **cancer** treatment by a **physician**.

Date of diagnosis for cancer (invasive), **carcinoma in situ or skin cancer** means the date the tissue specimen, blood samples or titer(s) are taken upon which an **insured person** receives **diagnosis** of **cancer (invasive)**, **carcinoma in situ** or **skin cancer**.

Maintenance drug therapy means ongoing treatment, such as hormone therapy (HT), immunotherapy or chemoprevention, which may be given to help keep **cancer (invasive)** or **carcinoma in situ** from coming back after it has disappeared following the primary treatment.

Pathological diagnosis is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of **diagnosis** must be done by a **pathologist** whose **diagnosis** of malignancy is in keeping with the standards established by the American Board of Pathology.

Pathologist means a **physician** who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A **pathologist** also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Skin Cancer means melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between Aetna and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Indemnity Benefits for you and your eligible dependents. Your Employer may also allow you to continue other coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage facility indemnity expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Medical Indemnity Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.

Additional Information Provided by
Sacred Heart University, Incorporated

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your *Booklet-Certificate*. Your Plan Administrator has determined that this information together with the information contained in your *Booklet-Certificate* is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan:
Sacred Heart University Health & Welfare Plan

Employer Identification Number:
06-0776644

Plan Number:
505

Type of Plan:
Critical Illness Plus with Cancer

Type of Administration:
Group Insurance Policy with:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

Plan Administrator:
Director of Employee Benefits
Sacred Heart University, Incorporated
5151 Park Avenue - Human Resources
Fairfield, CT 06825
Telephone Number: (203) 371-7921

Agent For Service of Legal Process:
Sacred Heart University, Incorporated
5151 Park Avenue - Human Resources
Fairfield, CT 06825

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:
December 31st

Source of Contributions:
Employee

Procedure for Amending the Plan:
The Employer may amend the Plan from time to time by a written instrument signed by the Director of Employee Benefits.

ERISA Rights

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. 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 and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an 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.

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

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 your interest and that of other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 materials 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a domestic relations order or a medical child support order, you may file suit in a 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, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.