

# YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of  
The Claremont Colleges

**GROUP CRITICAL ILLNESS INSURANCE  
CERTIFICATE OF COVERAGE  
RELIASTAR LIFE INSURANCE COMPANY**  
20 Washington Avenue South, Minneapolis, Minnesota 55401  
Claims: 888-238-4840 Customer Service: 877-236-7564

**POLICYHOLDER:** The Claremont Colleges  
**GROUP POLICY NUMBER:** 71223-0CCI2  
**POLICY EFFECTIVE DATE:** January 1, 2020  
**GOVERNING JURISDICTION:** California

**Benefits are paid for Critical Illnesses as defined in the Certificate. This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Benefits are paid under the Policy for Critical Illnesses as indemnity insurance and are not intended to cover medical expenses.**

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This certificate provides benefits for Cancer. The benefit amount payable is different for a diagnosis of Cancer (Invasive) or Cancer (Non-Invasive) or Skin Cancer. No benefits are payable for premalignant conditions or polyps. Refer to the SCHEDULE OF BENEFITS for benefit amounts. The definitions of Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer are located in the DEFINITIONS section. The differences in these definitions are primarily related to the growth and/or spread of abnormal cells or their potential to spread beyond their original site, as determined by a Doctor. The benefit amount payable for Cancer (Non-Invasive) and Skin Cancer may be substantially less than the benefit amount payable for Cancer (Invasive) due to these differences.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

**Please read your Certificate carefully.**

**RIGHT TO EXAMINE CERTIFICATE -If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.**

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

**RELIASTAR LIFE INSURANCE COMPANY  
P.O. Box 20, Minneapolis, Minnesota 55440**

**CONSUMER NOTICE**

**If you have a question about your Policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-888-238-4840.**

**You will need to provide your Policy number with any communication.**

**If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:**

**California Department of Insurance  
Consumer Communications Bureau  
300 South Spring Street, South Tower  
Los Angeles, California 90013**

**Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)  
Los Angeles: (213) 897-8921**

**Web Site: [www.insurance.ca.gov/01-consumers/101-help](http://www.insurance.ca.gov/01-consumers/101-help)**

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# RELIASTAR LIFE INSURANCE COMPANY

## OUTLINE OF COVERAGE

This outline is only a summary of certain provisions in your Certificate. You must consult the Policy and Certificate for contract provisions regarding coverage.

Category of Coverage: Specified Disease. This category of coverage is designed to provide, to persons insured, benefits ONLY when certain losses occur as a result of specified diseases. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Benefits: See the SCHEDULE OF BENEFITS and CRITICAL ILLNESS BENEFITS sections of the Certificate.

Exceptions, Reductions and Limitations: See the SCHEDULE OF BENEFITS, CRITICAL ILLNESS BENEFITS, and if applicable, the EXCLUSIONS sections of the Certificate.

Continuation of Coverage: See the GENERAL PROVISIONS section of the Certificate.

Premiums: Information about your premium contribution for coverage may be obtained from the Policyholder.

## SCHEDULE OF BENEFITS

**EMPLOYER:** The Claremont Colleges

**GROUP POLICY NUMBER:** 71223-0CCI2

**INSURED PERSON:**

You must write your name in the space provided so that it becomes your Certificate. The date you are eligible for coverage is described in the GENERAL PROVISIONS section.

**ELIGIBLE CLASS(ES)**

All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.  
Temporary and seasonal workers are excluded from coverage.

Employees who are not citizens or legal residents of the United States are excluded from coverage.

**MINIMUM HOURS REQUIREMENT**

20 hours per week.

**ELIGIBILITY WAITING PERIOD**

Persons in an eligible class on or before the Policy effective date: None

Persons entering an eligible class after the Policy effective date: None

**WHO PAYS FOR THE COVERAGE**

You pay the cost of your coverage.

**BENEFIT AMOUNT**

<u>Low Plan</u>	<u>High Plan</u>
\$15,000	\$30,000

**CRITICAL ILLNESS BENEFITS**

**Base module**

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Heart Attack	100%	\$30,000	\$60,000
Cancer (Invasive)	100%	\$30,000	\$60,000
Stroke	100%	\$30,000	\$60,000
Major Organ Transplant	100%	\$30,000	\$60,000
Coronary Artery Bypass	25%	\$7,500	\$15,000
Cancer (Non-Invasive)	25%	\$7,500	\$15,000

**Enhanced cancer module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for Low Plan coverage</b>	<b>Total maximum benefit amount for High Plan coverage</b>
Benign Brain Tumor	100%	\$30,000	\$60,000
Skin Cancer	10%	\$3,000	\$6,000
Bone Marrow Transplant	25%	\$7,500	\$15,000
Stem Cell Transplant	25%	\$7,500	\$15,000

**Quality of life module**

<b>Covered illness/condition</b>	<b>Percent of BENEFIT AMOUNT payable</b>	<b>Total maximum benefit amount for Low Plan coverage</b>	<b>Total maximum benefit amount for High Plan coverage</b>
Permanent Paralysis	100%	\$15,000	\$30,000
Coma	100%	\$30,000	\$60,000

## DEFINITIONS

**Active Employment** means you are working for the Employer for earnings that are paid regularly. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:

- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Temporary and seasonal workers are excluded from coverage.

**Benign Brain Tumor** means the diagnosis of a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including, but not limited to:

- Loss of vision;
- Loss of hearing; or
- Balance disruption.

For purposes of the Policy, the following are not considered Benign Brain Tumors:

- Tumors of the skull;
- Pituitary adenomas; and
- Germinomas.

Benign Brain Tumor does not include diagnosis of any of the following conditions prior to your coverage effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; and
- Turcot Syndrome.

**Bone Marrow Transplant** means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant.

Bone Marrow Transplant includes a clinical diagnosis and actual transplant that occurs before you are able to be added to the *Be The Match* registry.

**Cancer (Invasive)** means the diagnosis of a group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells. Cancer is limited to malignancies of solid tissue, blood or lymph tissue and includes leukemia, lymphoma and Hodgkin's disease. The diagnosis of Cancer (Invasive) must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards

For the purposes of the Policy, the following are not considered Cancer (Invasive):

- Cancer (Non-Invasive);
- Skin Cancer;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.



**Cancer (Non-Invasive)** (also known as carcinoma in situ) means the diagnosis of tumor cells tending toward malignancy but that do not invade the underlying tissue or have the ability to spread beyond the site from which they originate (e.g. malignant cells confined to the epithelium without penetration of the basement membrane). The diagnosis of Cancer (Non-Invasive) must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards.

For purposes of the Policy, the following are not considered Cancer (Non-Invasive):

- Cancer (Invasive);
- Skin Cancer;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

**Certificate** means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

**Coma** means the diagnosis of a continuous state of profound unconsciousness, characterized by having a Glasgow scale of 3; defined as the absence of:

- Eye opening;
- Verbal response; and
- Motor response.

The condition must require intubation for respiratory assistance and must not be medically induced.

“Continuous state of profound unconsciousness” means 14 consecutive days or longer.

**Coronary Artery Bypass** means the diagnosis of severe left main or multi-vessel coronary artery disease (such as a SYNTAX score  $\geq 23$ ) for which is advised an open heart coronary artery bypass surgery - a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels.

**Critical Illness** means any of the following as defined:

- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer (Invasive); or
- Cancer (Non-Invasive); or
- Coma; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Major Organ Transplant; or
- Permanent Paralysis; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke.

**Different Diagnosis** means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition. Note: A Cancer (Invasive) that has spread to a different area of the body is not a different illness/condition than the previously diagnosed Cancer (Invasive).
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs more than 12 months after the date of the previous diagnosis.

**Exception:** A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma, is not considered a Different Diagnosis regardless of the time period between diagnoses.

- A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer (Invasive) or Cancer (Non-Invasive).
- A diagnosis of Cancer (Non-Invasive) is considered a Different Diagnosis from Cancer (Invasive).

**Doctor** means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and who is providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

**Eligibility Waiting Period** means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

**Employee** means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

**Employer** means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

**Heart Attack** means the diagnosis of a clinical picture of myocardial infarction that was caused by a blockage of one or more coronary arteries. The medical evidence must be consistent with the diagnosis of heart muscle death. Significant electrocardiogram (EKG) changes must be seen, and one or both of the following must confirm the acute myocardial infarction (Heart Attack):

- Cardiac enzyme changes as typically seen with myocardial damage found in the blood (elevated CK-MB isoenzyme fraction or elevated troponins)
- Confirmatory imaging test, such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

A sudden cardiac arrest is not in itself considered a Heart Attack.

**Hospital** means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

**Insured Person** means an Employee covered under the Policy and whose coverage remains in effect according to the terms of the Policy.

**Major Organ Transplant** means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a Physician specialized in care of the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination. If you receive the transplant prior to placement on the network, the network requirement will be waived.

**Permanent Paralysis** means the diagnosis of total and permanent loss of the use of two or more limbs (arms or legs or combination) due to accident or sickness for a continuous period of at least 60 days.

Permanent Paralysis does not include paralysis as the result of a Stroke.

**Policy** means the written group insurance contract between us and the Policyholder.

**Policyholder** means the Employer to which the Policy is issued and who sponsors the coverage for its Employees.

**Same Diagnosis** means either of the following:

- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as a Critical Illness for which benefits were payable under the Policy, and that occurs within 12 months of the date of the previous diagnosis.
- A subsequent diagnosis of a Critical Illness that is for the same illness/condition (including a Cancer (Invasive) that has spread to a different area of the body) as an illness/condition diagnosed prior to your coverage effective date under the Policy, and that occurs within 12 months of the date of the previous diagnosis.

**Exception:** A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma, is considered the Same Diagnosis regardless of the time period between diagnoses.

**Skin Cancer** means the diagnosis of tumor cells tending toward malignancy and which invade the underlying tissue or are present in situ. The diagnosis of Skin Cancer must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This includes a clinical diagnosis whenever such diagnosis is consistent with professional medical standards.

Skin Cancer includes:

- Basal cell carcinoma and squamous cell carcinoma of the skin including squamous cell carcinoma in situ; and
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm or which is considered melanoma in situ. Melanoma that is deeper than 0.75mm is considered to be Cancer (Invasive) instead of Skin Cancer.

**Stem Cell Transplant** means the clinical diagnosis of a blood or bone marrow malignancy for which the need for a surgical stem cell transplant has been advised.

**Stroke** means the diagnosis of an acute cerebral event including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis of Stroke must be based on confirmatory neuroimaging studies and evidence of persistent neurological impairment confirmed at the time of discharge from a Hospital.

Stroke does not include:

- Transient ischemic attacks (TIA)
- Temporary neurological deficits lasting less than 24 hours that result from a variety of causes; can be a precursor to stroke; but, does not result in infarction/death of brain tissue.
- Ischemic disorders of the vestibular system;
- Brain injury related to trauma or infection; or
- Brain injury associated with hypoxia/anoxia or hypotension.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

### EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The date you apply for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

### EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy is canceled.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the grace period after a premium due date, if the premium is not paid.
- The last day you are in Active Employment.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

Termination of your coverage will be without prejudice to any claim originating prior to the effective date of such termination.

### POLICY CANCELLATION

We may cancel this Policy at any time by written notice delivered to the Policyholder, or mailed to the Policyholder's last address as shown on our records, stating when, not less than 31 days thereafter, such cancellation shall be effective. The Policyholder may cancel this Policy at any time by written notice delivered or mailed to us at our home office, effective on receipt or on such later date as may be specified in the notice. In the event of such cancellation by either us or by the Policyholder, we shall promptly return on a prorata basis the unearned premium paid, if any, and the Policyholder shall promptly pay on a prorata basis the earned premium which has not been paid. (In computing the prorata premium to be returned by us or to be paid by the Policyholder, any discounts in premium or premium rate actually allowed to the Policyholder because of the longer periods for which premiums, at the time of the cancellation, had been paid or agreed to be paid shall be disregarded, and the prorata return or payment of premium will be computed upon the basis of our regular and customary premium or premium rate for the coverage of this Policy.)

Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

## **PORTABILITY**

Portability means you have the option to continue your coverage after it would otherwise terminate if certain conditions are met. You must elect portability before you reach age 70.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder cancels coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy is canceled and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of cancellation.

## **GRACE PERIOD**

A grace period of 60 days will be granted for the payment of premiums accruing after the first premium during which grace period the Policy shall continue in force, but the Policyholder shall be liable to us for the payment of the premium accruing for the period the Policy continues in force.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force, but you shall be liable to us for the payment of the premium accruing for the period your coverage remains in force.

## **TIME LIMIT ON CERTAIN DEFENSES**

After three years from the date of issue of the Policy, no misstatement of the Policyholder, except a fraudulent misstatement, made in the application shall be used to void the Policy. After three years from your effective date of coverage under the Policy, no misstatements, except fraudulent misstatements, made by you in your application for coverage shall be used to deny a claim for loss incurred after the expiration of the three-year period.

## **CLERICAL ERROR**

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

**NOTICE OF CLAIM**

Written notice of claim must be given to us within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of you to us at P.O. Box 20, Minneapolis, MN 55440 or to our authorized agent, with information sufficient to identify you, shall be deemed notice to us.

**PROOF OF LOSS**

Written proof of loss must be furnished to us within 90 days after the date of such loss. Failure to submit such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

**TIME OF PAYMENT OF CLAIMS**

Indemnities payable under the Policy will be paid to you as they accrue immediately upon receipt of due written proof of such loss.

**PHYSICAL EXAMINATION**

At our expense, we shall have the right and opportunity to require you (your Person) to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

**BENEFIT PAYMENTS**

Benefits are payable to you unless otherwise specified. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your biological and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person's estate.

"Spouse" in this provision means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

**LEGAL ACTION**

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**MISSTATEMENT OF AGE**

If your age has been misstated, all amounts payable to you under the Policy shall be such as the premium paid would have purchased at the correct age.

**AGENCY**

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

**CONFORMITY WITH STATE STATUTES**

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued is automatically amended to conform to the minimum requirements of such law.

**CHANGES TO POLICY OR CERTIFICATE**

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

## CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on the SCHEDULE OF BENEFITS if you are diagnosed with a Critical Illness after your coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on the SCHEDULE OF BENEFITS.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of this certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

**Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor and Pre-Malignant Diagnosis, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$20,000 critical illness benefit amount. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25% and the percentage for Pre-Malignant Diagnosis is 10%. Under this example, benefits would be calculated as follows:**

- An Employee has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive).  $\$20,000 \text{ benefit amount} \times 100\% = \$20,000$ .
- Another Employee has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive).  $\$20,000 \text{ benefit amount} \times 25\% = \$5,000$ .
- Another Employee has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis meets the Policy definition of Pre-Malignant Diagnosis.  $\$20,000 \text{ benefit amount} \times 10\% = \$2,000$ .
- Another Employee has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Cancer (Invasive) or Cancer (Non-Invasive) and therefore no benefit is payable.

**These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of this Certificate.**

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable to you for each Critical Illness in the Certificate during your lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and your coverage (including all riders) terminates.

### BASE MODULE

**Benefits for Heart Attack, Cancer (Invasive), Stroke, Major Organ Transplant, Coronary Artery Bypass and Cancer (Non-Invasive)** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Heart Attack or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke. A diagnosis of Cancer (Invasive) or Cancer (Non-Invasive) must be made by a Doctor familiar with the specific condition.



If you are on the UNOS (United Network for Organ Sharing) list for a combined transplant, only one Major Organ Transplant benefit will be payable for the diagnosis.

### **QUALITY OF LIFE MODULE**

A Critical Illness under this module, other than Coma, is not eligible for multiple benefit payments.

**Benefits for Permanent Paralysis and Coma** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

### **ENHANCED CANCER MODULE**

**Benefits for Benign Brain Tumor, Skin Cancer, Bone Marrow Transplant and Stem Cell Transplant** are payable when we receive due proof of such condition which is diagnosed after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Benign Brain Tumor or Skin Cancer or Pre-Malignant Diagnosis must be made by a Doctor familiar with the specific condition.

# SPOUSE CRITICAL ILLNESS RIDER

## RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** The Claremont Colleges

**GROUP POLICY NUMBER:** 71223-0CCI2

**INSURED PERSON:**

**SPOUSE:**

You must write your name and your Spouse's name in the spaces provided so that it becomes your rider. The date your Spouse is eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### SPOUSE BENEFIT AMOUNT

<u>Low Plan</u>	<u>High Plan</u>
\$7,500	\$15,000

## SPOUSE CRITICAL ILLNESS BENEFITS

### Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Heart Attack	100%	\$15,000	\$30,000
Cancer (Invasive)	100%	\$15,000	\$30,000
Stroke	100%	\$15,000	\$30,000
Major Organ Transplant	100%	\$15,000	\$30,000
Coronary Artery Bypass	25%	\$3,750	\$7,500
Cancer (Non-Invasive)	25%	\$3,750	\$7,500

### Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Benign Brain Tumor	100%	\$15,000	\$30,000
Skin Cancer	10%	\$1,500	\$3,000
Bone Marrow Transplant	25%	\$3,750	\$7,500
Stem Cell Transplant	25%	\$3,750	\$7,500

### Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Permanent Paralysis	100%	\$7,500	\$15,000
Coma	100%	\$15,000	\$30,000

## SPOUSE CRITICAL ILLNESS BENEFITS

The benefit percentages for your Spouse are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate.

## DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

**Spouse** means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

### EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The date you apply for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

### EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

### TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.
- The date your Spouse's total maximum benefit amount has been paid for all Critical Illnesses.

### PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

## **PORTABILITY FOLLOWING DEATH OR DIVORCE**

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must be under age 70 and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease, but not increase, the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

## **PHYSICAL EXAMINATION**

At our expense, we shall have the right and opportunity to require your Spouse to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

## **BENEFIT PAYMENTS**

Benefits under this rider are payable to you. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

## **CRITICAL ILLNESS BENEFITS**

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Critical Illness after your Spouse's coverage effective date. The percentage of BENEFIT AMOUNT payable is listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS.

The benefits for your Spouse are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of the Certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor and Pre-Malignant Diagnosis, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$20,000 critical illness benefit amount. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25% and the percentage for Pre-Malignant Diagnosis is 10%. Under this example, benefits would be calculated as follows:

- A Spouse has a lump in her breast and she is diagnosed with stage III breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive).  $\$20,000 \text{ benefit amount} \times 100\% = \$20,000$ .
- Another Spouse has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive).  $\$20,000 \text{ benefit amount} \times 25\% = \$5,000$ .
- Another Spouse has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis meets the Policy definition of Pre-Malignant Diagnosis.  $\$20,000 \text{ benefit amount} \times 10\% = \$2,000$ .
- Another Spouse has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Cancer (Invasive) or Cancer (Non-Invasive) and therefore no benefit is payable.

These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of the Certificate and this rider.

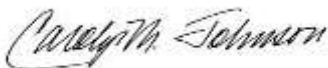
Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness in this rider during your Spouse's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount for your Spouse has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and this rider terminates.

Payment of any benefits for your Spouse's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Spouse's Critical Illness coverage as long as your coverage remains in force.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

# CHILDREN'S CRITICAL ILLNESS RIDER

## RELIASTAR LIFE INSURANCE COMPANY

20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** The Claremont Colleges

**GROUP POLICY NUMBER:** 71223-0CCI2

**INSURED PERSON:**

You must write your name in the space provided so that it becomes your rider. The date your Child is eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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### SCHEDULE OF BENEFITS

#### WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

#### CHILDREN'S BENEFIT AMOUNT

<u>Low Plan</u>	<u>High Plan</u>
\$5,000	\$10,000

## CHILDREN'S CRITICAL ILLNESS BENEFITS

### Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Heart Attack	100%	\$10,000	\$20,000
Cancer (Invasive)	100%	\$10,000	\$20,000
Stroke	100%	\$10,000	\$20,000
Major Organ Transplant	100%	\$10,000	\$20,000
Coronary Artery Bypass	25%	\$2,500	\$5,000
Cancer (Non-Invasive)	25%	\$2,500	\$5,000

### Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Benign Brain Tumor	100%	\$10,000	\$20,000
Skin Cancer	10%	\$1,000	\$2,000
Bone Marrow Transplant	25%	\$2,500	\$5,000
Stem Cell Transplant	25%	\$2,500	\$5,000

### Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Permanent Paralysis	100%	\$5,000	\$10,000
Coma	100%	\$10,000	\$20,000

## CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages for your Children are the same as the benefit percentages for you as shown in the SCHEDULE OF BENEFITS section of the Certificate. Benefit percentages for the Additional Child Diseases are shown below.

### Additional Child Diseases module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for Low Plan coverage	Total maximum benefit amount for High Plan coverage
Cerebral Palsy	100%	\$5,000	\$10,000
Congenital Birth Defects	100%	\$5,000	\$10,000
Cystic Fibrosis	100%	\$5,000	\$10,000
Down Syndrome	100%	\$5,000	\$10,000
Gaucher Disease, Type II or III	100%	\$5,000	\$10,000
Infantile Tay Sachs	100%	\$5,000	\$10,000
Niemann-Pick Disease	100%	\$5,000	\$10,000
Pompe Disease	100%	\$5,000	\$10,000
Type IV Glycogen Storage Disease	100%	\$5,000	\$10,000



## DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

**Additional Child Diseases** means in addition to the benefits provided for Critical Illnesses as defined in the Certificate, this rider also covers the following child diseases:

- Cerebral Palsy.
- Congenital Birth Defects.
- Cystic Fibrosis.
- Down Syndrome.
- Gaucher Disease, Type II or III.
- Infantile Tay Sachs.
- Niemann-Pick Disease.
- Pompe Disease.
- Type IV Glycogen Storage Disease.

This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

**Cerebral Palsy** means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder.

**Child or Children** means a child from live birth but less than 26 years of age who is one of the following:

- Your biological or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your registered domestic partner who is recognized as equivalent to a spouse by California law.
- A child of your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

The child must also meet all of the following conditions:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

**Congenital Birth Defects** means the malformation of an organ or organ system that results in the recommendation of surgery.

Examples include but are not limited to the following:

- Heart defects.
- Lung defects.

- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.

Congenital Birth Defects includes developmental disorders of the brain or being born blind without the recommendation of surgery.

Congenital Birth Defects does not include prematurity.

**Critical Illness** has the same meaning as in the Certificate. This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

**Cystic Fibrosis** means a definite diagnosis of cystic fibrosis by a licensed family practitioner, pediatrician or pulmonologist where the Child has chronic lung disease and pancreatic insufficiency. The diagnosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L on two independent tests.

**Down Syndrome** means diagnosis of down syndrome through a study of the 21<sup>st</sup> chromosome.

Down Syndrome includes:

- Trisomy 21 - an individual has three instead of two #21 chromosomes.
- Translocation - an extra part of the 21<sup>st</sup> chromosome is attached to another chromosome.
- Mosaicism - the individual has an extra 21<sup>st</sup> chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21<sup>st</sup> chromosomes.

**Gaucher Disease, Type II or III** means a definitive diagnosis of Gaucher Disease, Type II or III through a blood test reviewing beta-glucosidase leukocyte (BGL).

**Infantile Tay Sachs** means a definitive diagnosis of Infantile Tay Sachs through a blood test reviewing Hexosaminidase A levels.

**Niemann-Pick Disease** means a definitive diagnosis of Niemann-Pick, Type A, B, or C, through blood test or genetic test.

**Pompe Disease (Type II Glycogen Storage Disease)** means a definitive diagnosis of Pompe Disease (Type II Glycogen Storage Disease) through enzyme testing or genetic testing.

**Spouse** means your lawful spouse. It includes your registered domestic partner who is recognized as equivalent to a spouse by California law. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership. Any reference to divorce includes termination of a domestic partnership.

**Type IV Glycogen Storage Disease** means a definitive diagnosis of Type IV Glycogen Storage Disease through testing of glycogen branching enzyme deficiency in the liver, muscle, or skin, or through genetic testing.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

If both you and your Spouse are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may apply for Children's coverage under this rider within 60 days.

### EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The date you apply for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

Your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 30<sup>th</sup> day is subject to the conditions regarding application and Active Employment and having no approved Employee claims under the Policy.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

### EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

## **TERMINATION**

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child reaches age 26, unless he/she is disabled as defined under the definition of Child. Coverage of a disabled Child ends when there is no longer evidence satisfactory to us that the disability is continuing.
- The date your Child's total maximum benefit amount has been paid for all Critical Illnesses.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

## **PORTABILITY**

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

## **PORTABILITY FOLLOWING DEATH**

If you die and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

## **PHYSICAL EXAMINATION**

At our expense, we shall have the right and opportunity to require your Child to be examined as it relates to the Critical Illness that is the basis of the claim. We can require such examination when and as often as we may reasonably require during the pendency of a claim.

## **BENEFIT PAYMENTS**

Benefits under this rider are payable to you. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

## CRITICAL ILLNESS BENEFITS

The benefits for your Children are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate. Benefits for the Additional Child Diseases module are shown below.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis from any previously diagnosed Critical Illness or Additional Child Disease. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

**Critical Illness benefits, including benefits for Cancer (Invasive) and Cancer (Non-Invasive) and Skin Cancer and Benign Brain Tumor and Pre-Malignant Diagnosis, are based on diagnosis and not on treatment or expenses. As an example: A group policy has a \$10,000 critical illness benefit amount for Children. The percentage of the benefit amount payable for Cancer (Invasive) is 100% and the percentage for Cancer (Non-Invasive) is 25% and the percentage for Pre-Malignant Diagnosis is 10%. Under this example, benefits would be calculated as follows:**

- A Child has a lump in her breast and she is diagnosed with stage I breast cancer. This diagnosis meets the Policy definition of Cancer (Invasive).  $\$10,000 \text{ benefit amount} \times 100\% = \$10,000$ .
- Another Child has a lump in her breast and she is diagnosed with breast ductal carcinoma in situ (DCIS). This diagnosis meets the Policy definition of Cancer (Non-Invasive).  $\$10,000 \text{ benefit amount} \times 25\% = \$2,500$ .
- Another Child has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis meets the Policy definition of Pre-Malignant Diagnosis.  $\$10,000 \text{ benefit amount} \times 10\% = \$1,000$ .
- Another Child has a lump in her breast and she is diagnosed with atypical ductal hyperplasia (ADH). This diagnosis does not meet the Policy definition of Cancer (Invasive) or Cancer (Non-Invasive) and therefore no benefit is payable.

**These examples are for illustrative purposes only. Refer to the SCHEDULE OF BENEFITS for coverage amounts and covered conditions. All benefits are subject to the terms of the Certificate and this rider.**

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness and Additional Child Disease. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness and Additional Child Disease in this rider during your Child's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness or Additional Child Disease.

When the total maximum benefit amount for a Child has been paid for a Critical Illness or Additional Child Disease, no further benefits are payable for that Child for that Critical Illness or Additional Child Disease. When the total maximum benefit amount for a Child has been paid for all Critical Illnesses and Additional Child Diseases, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all Critical Illnesses and Additional Child Diseases, no further benefits are payable and this rider terminates.

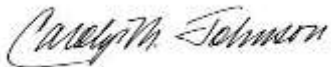
Payment of any benefits for your Child's Critical Illness or Additional Child Disease will not impact the available BENEFIT AMOUNT for your Critical Illness. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness or Additional Child Disease as long as your coverage remains in force.

A diagnosis of any Critical Illness or Additional Child Disease must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

#### **ADDITIONAL CHILD DISEASES MODULE**

Benefits for Cerebral Palsy, Congenital Birth Defects, Cystic Fibrosis, Down Syndrome, Gaucher Disease, Type II or III, Infantile Tay Sachs, Niemann-Pick Disease, Pompe Disease and Type IV Glycogen Storage Disease are payable when we receive due proof of such condition which is diagnosed after your Child's coverage effective date (including the effective date of any changes to coverage).

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

# CONTINUATION OF INSURANCE RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** The Claremont Colleges

**GROUP POLICY NUMBER:** 71223-0CCI2

### INSURED PERSON:

You must write your name in the space provided so that it becomes your rider. The date you are eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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## DEFINITIONS

### **Covered Person** means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

**Leave of Absence** means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

**Severance** means your Active Employment is terminated and continuation of insurance is available under a severance plan provided by the Employer.

## GENERAL PROVISIONS

### ELIGIBILITY

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Critical Illness coverage effective date.

## **EFFECTIVE DATE**

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

## **TERMINATION**

This rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

## **CONTINUATION OF INSURANCE**

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Severance,

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

## **EMPLOYER-APPROVED LEAVE(S) OF ABSENCE**

### **Family and Medical Leave**

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

### **Sickness or Injury**

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 9 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

### **Military Leave**

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.



**Sabbatical**

If you are on a Leave of Absence for an Employer-approved sabbatical, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

**Other Leave of Absence**

If you are on a Leave of Absence for any other reason, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

**SEVERANCE**

If your Active Employment terminates and Severance is available, then insurance coverage for all Covered Persons may be continued until the last day of the month which next follows the date which is 3 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

**CONCURRENT LEAVES OF ABSENCE**

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

**TERMINATION OF CONTINUATION**

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.
- The date of your death.
- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:

- Critical Illness insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

## **RETURN TO ACTIVE EMPLOYMENT**

If coverage is not continued during an FMLA or State FML Leave of Absence, and you return to Active Employment immediately following the end of the FMLA or State FML Leave of Absence and while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated effective the date you return to Active Employment. The amount(s) of coverage will be subject to the SCHEDULE OF BENEFITS in effect on the date you return to Active Employment. We will not apply a new Eligibility Waiting Period for the same or lesser amount(s) of coverage.

If coverage is not continued during your Leave of Absence for active military service, and you return to Active Employment while coverage is in force for Employees under the Policy, then coverage for all Covered Persons may be reinstated in accordance with USERRA and applicable state law.

If coverage is not continued during any other period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



William Bainbridge  
President



Melissa A. O'Donnell  
Secretary

# WELLNESS BENEFIT RIDER

## RELIASTAR LIFE INSURANCE COMPANY 20 Washington Avenue South, Minneapolis, Minnesota 55401

**POLICYHOLDER:** The Claremont Colleges

**GROUP POLICY NUMBER:** 71223-0CCI2

### INSURED PERSON:

You must write your name in the space provided so that it becomes your rider. The date you are eligible for coverage is described in the GENERAL PROVISIONS section of this rider.

This rider is made a part of the Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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General Provisions.....	2
Benefits.....	3

## SCHEDULE OF BENEFITS

### WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

### WELLNESS BENEFIT

You: \$50  
Your Spouse: \$50  
Your Children: 50% of your wellness benefit amount, to a maximum of \$100 for all Children in one calendar year

## DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

### Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse who is covered under your Spouse Critical Illness Rider.
- Your Children who are covered under your Children's Critical Illness Rider.

## **GENERAL PROVISIONS**

### **ELIGIBILITY**

If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

### **EFFECTIVE DATE**

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

### **TERMINATION**

This rider will terminate on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

### **PORTABILITY**

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

### **PORTABILITY FOLLOWING DEATH OR DIVORCE**

If you die or divorce and your Spouse is approved by us for portability under the Spouse Critical Illness Rider, then this rider can also be continued under your Spouse's coverage.

### **ASSIGNMENT**

At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

### **BENEFIT PAYMENTS**

Benefits under this rider are payable to you unless otherwise specified. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For Portability Following Death or Divorce, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment.

The PHYSICAL EXAMINATION provision in the Certificate and riders does not apply to this rider.

## BENEFITS

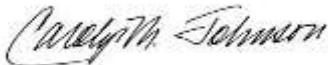
We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test.

A wellness benefit is limited to one annual payment per Policy year per Covered Person.

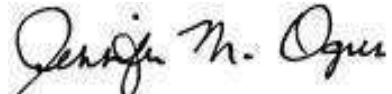
Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test;
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings

Executed at our Home Office:  
20 Washington Avenue South  
Minneapolis, MN 55401



Carolyn M. Johnson  
President



Jennifer M. Ogren  
Secretary

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

## SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by  
ReliaStar Life Insurance Company  
P.O. Box 122  
Minneapolis, Minnesota 55440-0122

**Plan Name, Number and Name and Address of Plan Sponsor:**

The Claremont Colleges Health & Welfare Benefits  
71223-0CCI2  
The Claremont Colleges  
101 South Mills Ave.  
Claremont, CA, 91711

**Name, Address, and Telephone Number of the Plan Administrator:**

The Claremont Colleges Services  
101 South Mills Ave.  
Claremont, CA, 91711  
909-621-8151

**Identification Numbers**

IRS Employer Identification Number: 95-4786748  
Plan Number: 522

**Agent for Legal Process:** Plan Administrator

**Trustees:** None

**Collective Bargaining or Multiple-Employer Agreements under which Plan is Established:** None

**Type of Administration:** Records maintained by Policyholder.

**Premium Payments:** Premiums are 100% Employee paid.

**Plan Year:** January 1 - December 31

**Claim Procedures:** Please refer to CLAIM PROCEDURES section(s).

**Statement of ERISA Rights:** Please refer to STATEMENT OF ERISA RIGHTS section.

**Eligibility and Circumstances Limiting Eligibility:** As described in the Certificate of insurance.

**Type of Plan:** As described in the Certificate of insurance.

**Benefits in Plan:** As described in the Certificate of insurance.

**Amendment or Termination of Plan:** The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

**Benefits, Rights, and Obligations after Termination:** As described in the Certificate of insurance.

## SUMMARY PLAN DESCRIPTION

### CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

- 1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
- 2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
- 3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
- 4) The notice of denial will be written in an understandable manner and include the following:
  - a. The specific reason(s) for the denial.
  - b. Specific reference to the provision which forms the basis of the denial.
  - c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
  - d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
- 5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
- 6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
- 7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
- 8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.



# SUMMARY PLAN DESCRIPTION

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). 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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, 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.

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