

Supplemental Life
Insurance
Plan



January 1, 2006

PLAN OUTLINE
Lourdes Health Network
Pasco, Washington

Supplemental Term Life Insurance Plan

Who Is Eligible	All active full-time and part-time non-exempt employees assigned to work at least 48 hours per pay period; and all active full-time exempt, management, and professional hourly employees assigned to work at least 40 hours bi-weekly per pay period
Service Requirement	Ninety days of continuous service in an eligible class
Eligibility Date	First day of the month on or following completion of the service requirement
Dependent Age Limit	To age 19 (23 if unmarried, full-time student)
Employee-Only Coverage Options	<ul style="list-style-type: none"> • 1X Basic Annual Earnings • 2X Basic Annual Earnings • 3X Basic Annual Earnings • 4X Basic Annual Earnings • 5X Basic Annual Earnings • Maximum \$1,000,000 • Minimum \$15,000
Spouse-Only Coverage Options*	<ul style="list-style-type: none"> • \$10,000 • \$25,000 • \$50,000 • \$75,000 • \$100,000
Children-Only Coverage Options*	<ul style="list-style-type: none"> • \$2,500 • \$5,000 • \$10,000
Your Cost for Coverage	You pay the full cost of this coverage. See your enrollment materials for the current rates.
Note:	*Spouse and dependent supplemental life available to Hourly employees and Registered Nurses the first day of month after completion of one year of service.

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Introduction

Through your Employer and the Ascension Health Supplemental Term Life Insurance Plan (the Plan), you can purchase additional life insurance coverage for yourself or for your Eligible Dependents if you are eligible.

The information in this Summary Plan Description (SPD) is intended to serve as a summary of the Ascension Health Supplemental Term Life Insurance Plan.

Certain words in this SPD are capitalized, and these words are defined in the Glossary in the next section. You may find it helpful to consult the Glossary as you read the SPD.

Please retain this SPD with your valuable papers. Coverage is effective only if you enroll and pay your premium.

Right to Amend or Discontinue the Plan

The Plan is based on current tax laws. Ascension Health and its participating Employers expect and intend to continue the Plan and its benefits as described in this SPD. However, Ascension Health reserves the right to amend, modify or terminate the Plan or any benefits provided under the Plan at any time and for any reason. In addition, your eligibility and participation in the Plan described in this SPD should not be construed as an employment contract.

If there are any discrepancies between the information in this SPD and the official Plan documents or certificates of insurance, the terms of the Plan documents and insurance certificates will prevail.

Glossary

The following terms may help you in reading and understanding this SPD.

Active Employment/Actively Employed A person working for his or her Employer for earnings paid regularly, and performing the material and substantial duties of his or her regular occupation. Normal vacation is considered Active Employment.

Basic Annual Earnings Your hourly rate of pay in effect at the time of your death multiplied by the number of hours you are authorized or scheduled to work during a regular pay period multiplied by the number of pay periods in a calendar year.

Because the amount of your benefit and the cost of coverage is based on your Basic Annual Earnings, a change in your Basic Annual Earnings during the year may affect your benefit and the cost of coverage. Please consult your flexible benefit plan (if applicable) or contact your Human Resources representative to determine whether a change in your Basic Annual Earnings will affect your benefit and the cost of coverage if your earnings change during the year.

Basic Life Insurance Life insurance benefits that are provided to you by your Employer at no cost to you.

Eligible Dependent An eligible spouse or dependent child who meets the dependent age limit as shown on the Plan Outline.

Employer Your W-2 employer, which is an eligible participating organization of Ascension Health.

Plan The group plan known as the Ascension Health Supplemental Term Life Insurance Plan.

Plan Outline A brief description of key features of the Ascension Health Supplemental Term Life Insurance Plan offered by your Employer.

Proof of Good Health Evidence of insurability as required by the insurance carrier. This may include a physical exam conducted by a doctor chosen by the insurance carrier.

Smoker Someone who has used tobacco in the last 12 months.

Section 1: Participating in the Plan

Who Is Eligible

You may purchase Supplemental Term Life Insurance for yourself and your dependents if you meet the eligibility and service requirements described on the Plan Outline. If you have any questions about your eligibility or your dependent's eligibility, contact your Human Resources representative.

You may elect to purchase coverage for your spouse and any unmarried dependent child(ren) residing in the United States. An Eligible Dependent child is:

- Your natural child who is dependent on you for support and maintenance
- An adopted child, including a child placed with you for the purpose of adoption
- A child who is primarily dependent on you for support and lives with you in a permanent parent-child relationship, and who is your stepchild, your foster child, or a child for whom you are a legal guardian.

Children must be under the dependent age limit shown on the Plan Outline to be eligible for coverage. Unmarried children under the dependent age limit shown on the Plan Outline who attend a licensed or accredited school on a full-time basis also are eligible. For coverage to continue during summer vacation periods, children must be scheduled to re-enter school on the next enrollment date.

Coverage will continue, through a special provision, for those children who became mentally or physically handicapped and unable to earn a living prior to attaining the dependent age limit and for whom proof of incapacity is furnished when required.

If both a husband and wife are covered under the Plan as Employees, either, but not both, may elect to cover dependent children. If the husband or wife elects to waive employee coverage, then he or she may be covered as a Dependent under the spouse's employee coverage.

Where a parent and a dependent child are both covered under the Plan as employees, the child may not be covered as a dependent of the parent.

In order to cover one dependent child, you must cover all your Eligible Dependent children, except as provided in the section entitled Late Enrollment.

Change in Dependent Eligibility In order to cover an Eligible Dependent who was not previously eligible, you must notify your Employer promptly to change your election. Your contribution amount may change to cover an additional Eligible Dependent.

You must notify your Employer when a dependent is no longer eligible for coverage.

When Coverage Begins and Ends

Employee-Only Coverage If you enroll, your coverage begins on the latest of the following events:

- The date you become eligible and enroll
- The date you enroll if you do so within one month after the date you became eligible, provided you have completed:
 - a full day of Active Employment on that date *or*

- a full day of Active Employment on your last regularly scheduled work day and are able to work on the date you become eligible.
- The date any required Proof of Good Health is approved by the insurance carrier.

If you are absent from work due to an injury, illness, layoff or leave of absence on the Plan effective date, your coverage or increase in coverage will begin on the date you return to Active Employment.

Your coverage ends on the earliest of the following events:

- The Plan ends
- You no longer are a member of an eligible class of employees
- The date ending the period for which your last contribution was made
- Your employment with the Employer ends (coverage will continue to the end of the period for which your last contribution was made)
- At the end of 12 months if not at work due to sickness or accident, unless approved for continuation of coverage due to a disability
- At the end of 12 months if on a documented leave of absence, other than one associated with the Family and Medical Leave Act
- At the end of 12 months if laid off due to a lack of work.

Dependent Coverage If you enroll your Eligible Dependents, coverage for your Eligible Dependents begins when your coverage begins. If, after you enroll yourself and your Eligible Dependents, you acquire an Eligible Dependent, coverage for your acquired Eligible Dependent will be available on the date you acquire your Eligible Dependent.

If a dependent is confined to a hospital when enrolled, coverage for that dependent will become effective on the day following the date of discharge.

Newborn Eligible Dependents (natural or adopted) will be covered even though the child is in the hospital if you already have a dependent child covered under the Plan.

If you are required to provide Proof of Good Health for a dependent, coverage will not begin until the insurance carrier approves the coverage.

Dependent coverage ends on the earliest of the following events:

- The date ending the period for which your last contribution was made
- Your coverage ends
- A dependent ceases to be eligible as a dependent.
- The date that adoption proceedings are discontinued unless the result of the proceedings finalizes the adoption.

How to Enroll

Enrollment is voluntary. If you would like to elect Supplemental Term Life Insurance coverage, you should do so within 31 days of when you first become eligible to participate in the Plan.

If you do not enroll during this eligibility period, you may later enroll during the annual enrollment period, after a qualifying change in status or at any other time during the year; however, you may be required to provide Proof of Good Health, as described in the next section, for yourself and your dependents.

If your Employer does not have annual enrollments, any request for coverage or coverage increase made more than 31 days after your hire date or your entry into an

eligible class of employees will require Proof of Good Health as described in the next section.

To enroll during your eligibility period:

- Select the coverage option that best fits your needs (see the Plan Outline for coverage options)
- Complete your Employer's enrollment process. Be sure to indicate your coverage options and the benefit amount.

Proof of Good Health

You may be required to provide Proof of Good Health for yourself or your eligible dependents if:

- You did not elect to purchase Supplemental Term Life Insurance when first eligible and now are electing this coverage
- Your Supplemental Term Life Insurance coverage exceeds \$500,000 or three times your Basic Annual Earnings (whichever is less). Your coverage will become effective only after the carrier accepts your Proof of Good Health
- You elect to reinstate coverage after your coverage ceases other than due to termination of employment or if your membership in an eligible class of employees changes so that you are no longer eligible to participate in the Plan
- You elect Supplemental Term Life Insurance coverage for your spouse that exceeds \$50,000
- Your increase in coverage is more than one benefit option higher than the current benefit option in which you or your spouse is currently enrolled.

You are *not* required to provide Proof of Good Health if:

- You elect to purchase Supplemental Term Life Insurance when first eligible
- Your coverage is less than \$500,000 or three times your Basic Annual Earnings (whichever is the lesser amount) and you are entering an eligible class of employees for the first time
- Your increase in coverage at annual enrollment is one benefit option higher than the current benefit option in which you are currently enrolled, unless your coverage will exceed \$500,000 or three times your Basic Annual Earnings
- Your spouse's increase in coverage at annual enrollment is one benefit option higher than the current benefit option in which your spouse is currently enrolled, unless the coverage for your spouse will exceed \$50,000
- Your spouse is going from no coverage to the lowest level of coverage during an annual enrollment period, unless the coverage for your spouse will exceed \$50,000.

When you are required to provide Proof of Good Health, the coverage or change in coverage will not become effective before the insurance carrier accepts your Proof of Good Health. Once the insurance carrier has accepted your Proof of Good Health, the coverage or change in coverage will become effective on the date of approval of your Proof of Good Health by the insurance carrier, provided you have completed either of the following:

- A full day of Active Employment on that date
- A full day of Active Employment on your last regularly scheduled work day if you are able to work on the date you become eligible.

When a dependent is required to provide Proof of Good Health, coverage will become effective for your dependent on the date of approval of good health by the insurance carrier, provided your dependent is not confined at home, in a hospital or other institution on that date.

Late Enrollment

Employee-Only Coverage If your Employer allows late enrollment and you apply more than 31 days after becoming eligible (except during an annual enrollment period), you must provide Proof of Good Health. Coverage will become effective on the date Proof of Good Health is approved by the carrier, provided you are Actively Employed.

Dependent Coverage If your Employer allows late enrollment and you apply for dependent coverage more than 31 days after becoming eligible (except during an annual enrollment period), you must provide Proof of Good Health for all of your non-covered Eligible Dependents, except for coverage amounts of \$10,000 or less for dependent children. Coverage for each of your Eligible Dependents will become effective on the date that the insurance carrier approves Proof of Good Health. If the carrier does not approve Proof of Good Health coverage will not become effective.

Changing Your Enrollment

If you do not enroll yourself or your Eligible Dependents when first eligible, you may enroll for coverage during the annual enrollment period or no later than 31 days following a qualifying change in status. Qualifying change in status means a change as a result of:

- Your marriage or divorce
- The birth of a child

- The adoption, or placement in your home pending an adoption, of a child
- The death of a dependent
- The loss or gain of your employment or your spouse's employment, or a change in your work status or your spouse's work status affecting coverage
- Any other qualifying change as allowed by federal law and your Employer
- Certain court records.

If you are covered under a flexible benefits plan, refer to that plan for special limitations on changing coverage.

Any qualifying change in status must be reported to your Human Resources representative within 31 days of the event. To add your spouse and/or eligible children, obtain the appropriate form from your Human Resources representative and make any necessary changes. You must enroll your adopted children within one month of the date of adoption or date of placement, whichever is earlier.

Naming a Beneficiary

You may name anyone as your beneficiary except your Employer. You should designate a beneficiary at the time you first enroll for coverage. You are automatically the beneficiary for your Eligible Dependents.

You may change your beneficiary at any time by giving notice in writing. The effective date of the change is the date the request is signed. However, the insurance carrier is not liable for any amount paid before the request is received.

Your Cost for Coverage

Once you enroll, the cost of your coverage (premium) will be deducted from your paycheck. You pay the entire cost for your coverage.

Section 2: Plan Benefits

Benefit Amount

Employee-Only Coverage Coverage options and benefit amounts are shown on the Plan Outline. The insurance carrier will pay the benefit amount to your beneficiary if you die from any cause while covered under the Plan.

Dependent Coverage Coverage options are shown on the Plan Outline. Since you are the beneficiary for your dependents' coverage, the benefit amount for the death of a covered dependent is payable to you.

Payment of Death Benefits

Employee-Only Coverage If you die while covered under the Plan, your beneficiary(ies) will receive your benefit. If you name more than one beneficiary, each beneficiary will share equally unless you specify otherwise. If a beneficiary predeceases you, his or her share will be paid equally to the surviving beneficiaries, unless you state otherwise. Any amount for which a beneficiary is not named will be paid in the following order:

- To your surviving spouse
- If you do not have a surviving spouse, in equal shares to your surviving children
- If you do not have any surviving children, in equal shares to your surviving parents
- If you do not have any surviving parents, in equal shares to all of your surviving brothers or sisters
- If you do not have any surviving brothers or sisters, to the executors or administrators of your estate.

If contingent beneficiaries are named, the benefit amount will be paid in equal shares unless otherwise stipulated.

Dependent Coverage If your dependent dies while covered under the Plan, you will receive the elected benefit amount. Payment will be made after the carrier receives proof of death.

Living Benefit Option

Employee-Only Coverage If you become terminally ill while covered under this Plan or while your coverage is being continued during a period of disability that began before age 60, you may apply for the living benefit option. This election is allowed only once in your lifetime and is subject to the conditions shown below. Terminally ill means you are expected to die within 12 months. This must be certified by a doctor and accepted by the insurance carrier. At the time such proof is given, the insurance carrier may require you to be examined by a doctor of its choice and at its expense.

The amount of the Living Benefit will be as follows:

- Up to 75% of your Supplemental Term Life benefit amount, if that amount is at least \$10,000 to a maximum of \$250,000
- Determined as of the date the insurance carrier accepts proof that you are terminally ill
- Payable only if you are living when payment is made

You will not be able to increase your life insurance benefit after the insurance company approves your living benefit.

The amount payable to your beneficiary upon your death, plus the amount payable to you as a Living Benefit, cannot exceed the benefit amount that would have been payable to your beneficiary if you had not applied for the Living Benefit.

The amount available for you to convert to a personal policy will be reduced by the amount of any Living Benefit paid to you.

The Living Benefit Option will *not* be available if:

- You have assigned your life insurance benefit
- The insurance carrier has been notified that all or a portion of your life insurance benefit is to be paid to your former spouse as part of a divorce agreement or court order
- You are over age 70 when you apply for the Living Benefit Option
- A terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted injury while sane.

Spouse If your spouse becomes terminally ill while covered under this Plan, you may apply for the Living Benefit Option. This election is allowed only once in your lifetime and is subject to the conditions shown below. Terminally ill means your spouse is expected to die within 12 months. This must be certified by a doctor and accepted by the insurance carrier.

The Living Benefit Option will be payable when the insurance carrier receives acceptable proof from your doctor that your spouse is terminally ill. At the time such proof is given, the insurance carrier may require your spouse to be examined by a doctor of its choice and at its expense.

The amount of the Living Benefit for your spouse will be as follows:

- Up to 75% of your spouse's Supplemental Term Life benefit amount, if that amount is at least \$10,000
- Determined as of the date the insurance carrier accepts proof that your spouse is terminally ill

- Payable only if your spouse is living when payment is made.

The amount payable to you upon your spouse's death, plus the amount payable to you for this Living Benefit cannot exceed the benefit amount that would have been payable to you if your spouse had not applied for the Living Benefit.

The amount available for your spouse to convert to a personal policy will be reduced by the amount of any Living Benefit paid to you.

The Living Benefit Option will *not* be available if:

- Your spouse's benefit amount is less than \$10,000
- You are over age 70 when your spouse applies for the Living Benefit option.

Benefits paid under the Living Benefit Option may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact on this benefit.
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Changing the Amount of Coverage

Your coverage level may change automatically because of changes in your age or Basic Annual Earnings. The effective date of such coverage changes will be determined under your Employer's policies. See your Human Resources representative for more information.

You may also request a change in the benefit amount subject to any requirements by the insurance carrier for you to provide Proof of Good Health:

- During open enrollment, you may change the amount of coverage for yourself and your dependents

- After a qualifying change in status, you may also change your own benefit amount no later than 31 days after the event (see Changing Your Enrollment in Section 1)
- Any other time of the year as allowed by your Employer, you may change the level of coverage for yourself or your dependents.

How to Make Voluntary Changes If you want to increase or decrease the amount of coverage for yourself and/or your dependents, you must submit a change in coverage to your Human Resources representative.

If you are covered under a flexible benefits plan, refer to that plan for special limitations on changing coverage.

When Changes Become Effective If your voluntary change in coverage requires Proof of Good Health, the change in coverage will become effective when Proof of Good Health has been approved by the insurance carrier. If Proof of Good Health is not required:

- After open enrollment, any voluntary change in the amount of coverage made will become effective on the first day of the benefit year beginning with or after the date of change in benefit option
- After a voluntary change in coverage due to a qualifying change in status, coverage will become effective on the later of the date of the qualifying change in status or the date you make the election change.

You must be Actively Employed for any increase to become effective.

Benefit Reduction at Age 70

Employee-Only Coverage Your benefit amount will be reduced by 50% when you reach age 70. Please note that this reduction in benefit may reduce your benefit amount below the minimum amount stated on the Plan Outline.

Dependent Coverage Your spouse's benefit amount will be reduced by 50% when you reach age 70. Children's benefit amounts will not change.

Suicide Exclusion

If death is due to suicide while sane or insane, no benefit will be payable for:

- Coverage that started less than two years prior to death
- Any increase in coverage that took place less than two years prior to death, except if due to salary increases or a change in job classification.

Section 3: Other Plan Provisions

Continuation of Coverage While Disabled

If you become totally disabled due to injury or illness and you make written notice of the claim, your coverage may be continued, at no cost to you, to the earliest date that:

- You no longer are totally disabled
- You fail to furnish proof of total disability
- You fail to undergo an insurance carrier-required medical examination as to the extent of disability
- You no longer are eligible as determined using the following table:

Age When Totally Disabled	Continuation of Coverage
Prior to age 60	To age 65
Ages 60 through 64	Five years
Ages 65 through 69	To age 70, but not less than 12 months
Ages 70 and over	12 months

Totally disabled means that, as a result of an injury or illness, you are:

- Completely and continuously unable to perform the material and substantial duties of your own occupation
- Receiving treatment for your disability while under the regular care and attendance of a licensed doctor
- Not gainfully employed in an occupation for which you are or could become qualified by education, training or experience.

You must provide proof of disability acceptable to the insurance carrier while you are living and totally disabled, but no later

than one year after your date of disability. Subsequent proof of disability may be required by the insurance carrier.

Any reductions in the benefit amount as provided in Section 2, Plan Benefits, will apply to any coverage being continued under this provision.

If you die before providing proof of disability, your beneficiary will receive the amount of insurance then in effect provided proof of disability is received within one year of your death. If a converted policy is issued under the Plan, it must be returned without claim before coverage will be continued under this provision. Any premiums paid for the converted policy will be returned to you.

If you die prior to the time you were required to furnish proof, any amount of insurance paid under this provision will be reduced by the amount of the converted policy.

However, if the converted policy is returned without claim, the amount of the policy will be paid to your beneficiary as a benefit under the Plan. All premiums paid under the converted policy also will be paid to your beneficiary.

The insurance carrier may require you to be examined by a doctor of its choice.

If you qualify for continued coverage during disability, your Eligible Dependents must convert their coverage to an individual policy to maintain coverage (see Conversion of Life Insurance in this section).

Family and Medical Leave Act of 1993

Your Employer may allow you to continue your coverage and the coverage for your dependents during a leave of absence in accordance with the Family and Medical

Leave Act of 1993 (FMLA). Please check with your Human Resources representative.

Continuation of Coverage for Handicapped Children

Coverage may be continued for a dependent child who is mentally or physically disabled and unable to earn a living and who is dependent upon you for support. You must furnish proof of the dependent's disability and continue to make any required contribution within 31 days after the dependent reaches the dependent age limit (see Plan Outline).

Any coverage continued for such dependent child will end on the sooner of the following dates:

- The date the plan ends
- The date ending the period for which your last contribution was made
- The handicap ends
- The end of the 31-day period after any required proof is not furnished
- The date you no longer are a member of an eligible class of employees
- The date your employment with the employer ends (coverage will continue to the end of the period for which your last contribution was made)
- The date you qualify for continued coverage during disability
- The date your coverage ends due to sickness or accident, leave of absence other than FMLA, or layoff due to lack of work.

Portability of Coverage

Employee-Only Coverage If your Supplemental Term Life Insurance ends because your employment ends, you may continue your coverage by paying the premiums directly to the insurance carrier. You must apply for portable coverage and

pay the first premium within 31 days after the date your coverage ends.

To be eligible for this portability feature, you must be under age 70 when your coverage under the Plan ends.

You may elect to continue up to 100% of your Supplemental Term Life Insurance coverage in effect on the day your coverage ends or \$500,000, whichever is less.

Portability is not available if your coverage ends because of any of the following:

- The Plan is terminated or amended
- You failed to make a required premium contribution.

If you elect portability, your continued coverage will be governed by the terms of the Group Life Insurance Continuation Policy. The premiums will be at the group rates established for the Group Life Insurance Continuation Policy. You may obtain information from your Employer on the benefit features and pricing of this coverage. Portability coverage will terminate on the date you reach age 70 or fail to make a required premium payment. Conversion is available upon termination of coverage.

Any portion of your Supplemental Term Life Insurance coverage that you do not elect for portability may be converted to an individual policy according to the conversion provision. The amount you choose to convert, plus the amount you elect for portability, cannot exceed your Supplemental Term Life Insurance benefit amount.

Dependent Coverage If your covered spouse's or children's Supplemental Term Life Insurance ends because your employment ends, your Supplemental Term Life Insurance may be continued by paying

the premiums directly to the insurance carrier.

As long as you elect portability coverage, you may choose to elect portability coverage for your spouse's or children's coverage.

Portability is not available if dependent coverage ends as a result of the following:

- The Plan is terminated or amended
- You failed to make a required premium contribution.

To elect portability coverage for your spouse or dependent, you must, within 31 days of becoming eligible, submit a portability application and the required premium to the insurance carrier.

Any portion of Supplemental Term Life Insurance coverage that you do not elect for portability may be converted to an individual policy according to the terms of the conversion privilege. The amount converted cannot exceed your Supplemental Term Life Insurance benefit amount.

Your spouse and children's coverage under the portability of coverage provision will end at the earliest of the following dates:

- The group portability provision terminates
- The date ending the period for which your last payment was made
- The date your spouse reaches age 70
- For child coverage, the date you or your spouse are no longer covered or a covered child reaches the dependent age limit as shown on the Plan Outline
- A dependent ceases to be an Eligible Dependent (dependent coverage ends).

Conversion of Life Insurance

Employee-Only Coverage If your coverage ends because your employment ends or you are no longer a member of an eligible class of employees and you are not eligible for continued coverage under the portability option, you may convert your coverage to an individual policy.

You must apply for the conversion within 31 days after your coverage ends. Proof of Good Health is not required.

The premium for the policy will be based on your:

- Age
- Form and amount of policy.

Dependent Coverage You may convert your dependents' coverage to an individual policy if any of the following apply:

- Your employment ends
- You die
- You cease to be in an eligible class
- A dependent marries
- A dependent attains the maximum dependent age limit.

The dependent must apply for the policy within 31 days after the coverage ends. Proof of Good Health is not required.

The premium for the policy will be based on your dependent's:

- Age
- Form and amount of policy.

If your coverage is being continued because of disability and you recover or fail to give any required proof of disability, you may convert your coverage. To do so you must apply within 31 days from the date of recovery or from the date proof was required.

The converted policy will become effective at the end of the 31-day period allowed for conversion. If you die during that period, the amount of coverage you could have converted will be paid to your beneficiary. If you are disabled and you are covered under an approved waiver of premium, only one benefit will be paid to your beneficiary if you die during this 31-day period. A second benefit will not be paid under this conversion provision.

Section 4: Filing a Claim

Claim forms are available from your Human Resources representative or the claims administrator. Completed claims forms must be returned to the claims administrator.

If additional information is required, you will receive a request, in writing, specifying the nature of the information needed and an explanation as to why it is needed.

Determination of Benefits

If your claim for a benefit is denied in whole or in part, the claims administrator will provide you with written or electronic notice of any adverse benefit determination within 90 days after receipt of the claim, unless special circumstances require an extension of time for processing the claim. If the claims administrator determines that an extension of time is required, the claims administrator will notify you in writing of the extension before the end of the initial 90-day period, indicating the special circumstances requiring the extension of time and the date by which the claims administrator expects to make the decision. No such extension can exceed a period of 90 days from the end of such initial period.

Every notice of an adverse benefit determination will be provided in writing or electronically and will set forth the specific reasons for the denial, references to specific Plan provisions on which the denial is based, a description of additional materials or information necessary to perfect the claim, an explanation of why such material or information is necessary, and a description of the Plan's claim review procedures and the time limits applicable to such procedures.

Appeal of Adverse Benefit Determination

If you make a request for review within 60 days after you receive notice of an adverse benefit determination, you are entitled to a review of the decision by the claims administrator. The claims administrator will notify you of the benefit determination on review within 60 days after receipt of the request for review, unless special circumstances require an extension of time for processing the claim. If the claims administrator determines that an extension of time is required, the claims administrator will notify you in writing of the extension before the end of the initial 60-day period, indicating the special circumstances requiring the extension and the date by which the claims administrator expects to make a decision on review. No such extension can exceed a period of 60 days from the end of the initial period. Notice of the decision on review will be provided in writing or electronically and will include specific reasons for the adverse determination, references to specific Plan provisions on which the benefit determination is based and a description of any available voluntary appeal procedures and information about such procedures.

You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You may submit written comments, documents, records and other information relating to your claim. You also have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act if you are not satisfied with the decision on review.

Misrepresentations

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurance carrier, submits an application or files a claim containing a false, incomplete or misleading statement is guilty of insurance fraud. The insurance carrier reserves the right to take appropriate action in any instance where insurance fraud is an issue.

A “contestable” period, starting with the effective date of your insurance and continuing for two years (while you are living), is available to the insurance carrier. What this means is that, during the two years, the insurance carrier can contest the validity of your insurance because of inaccurate or false information received relating to your and your insured dependent's insurability. Only statements that are in writing and signed by you or your insured dependent can be used to contest the insurance.

Section 5: Your ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). They are described below.

Receiving Information About Your Plan and Benefits

You have the right to:

- 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 Pension and Welfare Benefits 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 welfare benefit or exercising your rights under ERISA.

Enforcing Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that the 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 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 your Employer. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Section 6: Plan and Contact Information

Official Plan Name	Ascension Health Life Insurance Plan (Supplemental Term Life Insurance)
Employer Identification Number	31-1662309
Plan Number	512
Plan Description	Supplemental Term Life Insurance
Plan Sponsor and Administrator	Ascension Health 4600 Edmundson Road St. Louis, MO 63134 (314) 253-6700
Type of Administration	Insured Plan
Plan Year	Plan records are maintained on a Plan-year basis beginning January 1 and ending December 31 each year.
Agent for Service of Legal Process	Ascension Health 4600 Edmundson Road St. Louis, MO 63134 (314) 253-6700
Type of Funding	You pay the entire cost of this benefit.

Contact Information

To File a Claim or Appeal	Claims Administrator ING Employee Benefits ReliaStar Life Insurance Company P.O. Box 1548 Minneapolis, MN 55440
Insurance Carrier	Group Policy Number: 63301-1 ING Employee Benefits ReliaStar Life Insurance Company 20 Washington Avenue South Minneapolis, MN 55401
Trustee	Group Policy Number: 63301-1 State Street Bank and Trust Company P.O. Box 1992 Boston, MA 02105-1992
