

Long-Term Disability Plan



January 1, 2009

PLAN OUTLINE

**Lourdes Health Network
Pasco, WA**

Long-Term Disability Plan

Who Is Eligible	Class I: All active full-time and part-time exempt, management, and professional hourly Employees assigned to work at least 40 hours bi-weekly per pay period.	
Service Requirement	Ninety (90) days of active employment in a benefit eligible position.	
Eligibility Date	First day of the month following completion of the service requirement.	
Benefit Amount	Core Benefit: 60% of Monthly Earnings Optional Benefit: 70% (10% buy-up) of Monthly Earnings NOTE: This benefit is subject to reductions as described in the section <i>Other Income Benefits</i> .	
Maximum Benefit Duration	<u>Age When Disability Begins</u>	
	Less than 60 60 61 62 63 64 65 66 67 68 69 and over	<u>Maximum Benefit Duration</u> To age 65 60 Months 48 Months 42 Months 36 Months 30 Months 24 Months 21 Months 18 Months 15 Months 12 Months
Elimination Period	Benefits begin on the 91 st consecutive calendar day of Disability, according to the election by the employee.	
Continuation of Coverage During Certain Absences	None	
Social Security Offset	Family	
Rehabilitative Employment Offset	50% after 24 months	
Basic Annual Earnings	Your hourly rate of pay in effect at the time of your Disability 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.	
Your Cost for Coverage	You and your Employer share in the cost of this coverage. Lourdes Health Network pays the full cost of the core benefit; you pay the full cost of the Optional Benefit elected. See your enrollment materials for current rates.	

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Introduction

Your Ascension Health Long-Term Disability Plan (the Plan) continues a portion of your pay if you are unable to work because of a disability. The Plan provides Long-Term Disability benefits to eligible Employees of participating Employers.

The information in this summary plan description (SPD) is intended for use as a summary of the Ascension Health Long-Term Disability Plan (Amended and Restated as of January 1, 2006).

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.

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, the terms of the Plan documents will prevail. The official Plan documents consist of the Plan and applicable adoption agreements.

Glossary

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

Actively at Work/Active Work You will be considered Actively at Work or doing Active Work with your Employer on a scheduled work day if:

- You are performing in the customary manner all of your regular duties for at least half of the scheduled work day either at one of your Employer's business establishments or at some location to which the Employer's business requires you to travel; and
- You are paid Basic Monthly Earnings; and
- You work at least the minimum number of hours in an Eligible Class as stated on the Plan Outline.

If you worked on your last scheduled work day, you will be considered Actively at Work on a scheduled non-work day, provided you were not Disabled and otherwise met the requirements for being Actively at Work. For example, if you worked on a Friday on which you were scheduled and you were not scheduled on the immediately following Saturday and Sunday, you would be considered to be Actively at Work on that Saturday and Sunday if you otherwise met the requirement for being Actively at Work on Friday.

You must work at least half of the last scheduled work day in order for that day to be credited as a day worked.

Basic Annual Earnings Refer to the Plan Outline for definition. **Basic Monthly Earnings** Your Basic Annual Earnings divided by 12. **Basic Weekly Earnings** Your Basic Weekly Earnings are your Basic Annual Earnings divided by 52.

Claims Administrator The persons or entities appointed to serve as Claims Administrator, which have been identified in "Section 6: Plan and Contact Information" of this SPD.

Disability/Disabled You are considered to be Disabled or to have a Disability if due to an Injury or Sickness that is supported by objective medical evidence, you require and are receiving the regular, ongoing medical care of a Licensed Physician and you are following the course of treatment recommended by the Licensed Physician. In addition, one of the following is true:

- You are unable to perform during the first 24 months of benefit payments, or eligibility for benefit payments, each of the Material Duties of your Regular Occupation, and after the first 24 months of benefit payments or eligibility for benefit payments, any work or service for which you are reasonably qualified taking into consideration your training, education, experience and past earnings *or*
- While unable to perform all of the Material Duties of your Regular Occupation on a full-time basis you are:
 - performing at least one of the Material Duties of your Regular Occupation or any other work or service on a part-time or full-time basis *and*
 - your earnings from work, while Disabled, do not exceed 80% of your pre-disability Basic Monthly Earnings.

Eligibility Date The date an Employee becomes eligible for coverage as described on the Plan Outline.

Eligible Class The classification of Employees eligible for coverage as described on the Plan Outline.

Elimination Period The number of consecutive calendar days of Disability before benefits become payable under the Plan. Your Elimination Period is identified on the Plan Outline and begins on the first day of Disability.

Employee A person who is employed by or provides services to an Employer and includes any person or class of persons designated as an Employee in the Plan Outline as required or permitted by law.

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

Gross Benefit Your benefit amount without any reduction for Other Income Benefits, taxes and compensation earned while you are Disabled.

Hospital/Institution An accredited facility licensed to provide care and treatment for the condition causing your Disability. This facility must provide 24-hour nursing services by registered graduate nurses and not specialize as a rest home, convalescent home or home for the aged.

Injury Any accidental bodily injury that results – directly and independently of all other causes – in a loss covered under the Plan. The Plan does not provide benefits for certain injuries described as “General Exclusions” in “Section 3: Other Plan Provisions” of this SPD.

Licensed Physician A person who is operating within the scope of his/her license and is licensed to practice medicine and

prescribe and administer drugs. This means, for example, chiropractors and psychologists cannot certify Disability under the Plan. The Claims Administrator may, in its discretion authorize temporary benefits allowing the Employee to seek treatment with a licensed physician but not in excess of four weeks. A Licensed Physician will not include any individual who is related to you. A licensed psychiatrist must supervise all treatment of Disabilities related to Mental Illness.

Material Duties The essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience generally required by employers from those engaged in a particular occupation that cannot be reasonably modified or omitted.

Maximum Benefit Duration The greater of:

- The benefit duration limit as shown in the table below *or*
- Your normal retirement age as defined by the Social Security Act.

For Disabilities beginning at age	While you are Disabled, payments continue
Before 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

- The Maximum Benefit Duration period does not include the Elimination Period.

Mental Illness A mental, emotional or nervous condition that is identified in the Diagnostic and Statistical Manual of Mental Disorders and that is certified and treated by a licensed psychiatrist. If your primary care physician (but not a psychiatrist) has determined that you have a Mental Illness, the Claims Administrator may, in its discretion, authorize temporary benefits. You then will be required to obtain certification and treatment by a licensed psychiatrist within the period specified by the Claims Administrator (which shall not exceed four (4) weeks). If you fail to obtain certification of your Mental Illness and treatment by a licensed psychiatrist within the time frame prescribed by the Claims Administrator, no further benefits shall be paid with respect to the Mental Illness.

Other Income Benefits Any reductions to the Gross Benefit. These reductions are described in the Other Income Benefits section of this SPD.

Plan The Ascension Health Long-Term Disability Plan.

Plan Administrator Ascension Health, a not-for-profit corporation, formed under the laws of the State of Missouri, or any other entity which may succeed to the rights, powers, duties and liabilities of Ascension Health with respect to this Plan.

Plan Outline A brief description of key features of the Ascension Health Long-Term Disability Plan, which your Employer has adopted in its adoption agreement to the Plan.

Preexisting Condition An Injury or Sickness or any related Injury or Sickness that was in existence within the three-month period ending on the day immediately before the date you became covered under this Plan or the date any increased benefit amount option becomes effective.

Recurrent Disability A Disability that is contributed to by or due to the same cause or causes as a prior Disability for which a benefit was paid under the Plan.

Regular Occupation The activities that you regularly performed when your Disability began. In addition to the specific position or job you hold with your Employer, it also includes other positions and jobs for which you have training and/or education to perform in your profession at your Employer or any other employer. If your Regular Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Regular Occupation is as broad as the scope of your license.

Rehabilitation A program designed to help you return to regular Active Work. Such a program must be approved by the Claims Administrator and your Employer and may include training, modified duty, physical therapy placement, or full-time or part-time work in your Regular Occupation at the time of Disability or in another occupation.

Rehabilitative Employment Employment on a limited basis as part of a Rehabilitation plan, the goal of which is to return you to the level of gainful employment that existed prior to your Disability.

Retirement Disability Benefit A benefit that:

- Is payable under a Retirement Plan due to Disability as defined in that plan
- Does not reduce the amount of the benefit that would have been paid as a retirement benefit at normal retirement age if the Disability had not occurred. (If the payment causes such a reduction, it will be considered a retirement benefit.)

Retirement Plan The Retirement Plan sponsored by your Employer or any former employer including the Ascension Health

matched savings and automatic contribution plans. The term Retirement Plan does not include a savings plan such as an Internal Revenue Code Section 403(b) or 401(k) plan.

Sickness An illness, disease, medical condition or pregnancy.

Section 1: Participating in the Plan

Who Is Eligible

You are eligible to participate in the Plan if you meet the eligibility and service requirements listed on the Plan Outline.

Unless your Employer's policies provide otherwise, you will not be eligible for Plan benefits while you are on personal, educational, or military leaves of absence or on disciplinary suspension. However, your Employer may permit your coverage to continue while you are on a leave of absence or sabbatical. See your employee handbook or policy manual for further details.

When Coverage Begins

Coverage begins on the Eligibility Date indicated on the Plan Outline. If the Plan is Contributory or Voluntary, you must also complete any required enrollment materials and make any required contributions before coverage will begin.

Coverage under the Plan will be delayed if you are not Actively at Work on the day that your coverage would normally begin, unless you were out on a scheduled day off for reasons other than Sickness or Injury (e.g., vacation). If you are not Actively at Work on the day coverage normally would begin, coverage will begin on the day you return to Active Work. The effective date for any increased or additional coverage will also be delayed in the event you are not Actively at Work on the date that the increased or additional coverage normally would begin. Again, such increased or additional coverage will become effective on the day you return to Active Work.

How to Enroll

If enrollment is required, your Human Resources representative will provide you with enrollment information.

Changing Your Enrollment

The level of coverage selected during the annual enrollment period cannot be changed during the year unless you have a change in family status. Change in family status refers to one of the following events:

- Your marriage or divorce
- The birth of a child
- The adoption, or placement in your home pending adoption, of a child
- The death or Disability of your spouse or child
- The termination of your spouse's employment or a change in spouse's employment status from full-time to part-time, or vice versa
- Any other family status change permitted by Federal law and your Employer.

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

If, as an active Employee, you make an election to increase coverage and then become unable to work because of a Sickness or Injury, any increased coverage amount resulting from your election will not be effective until you return to Active Work on or following the effective date of any increased benefit amount option.

Preexisting Condition Exclusion

The Plan does not provide Benefits for any Disability that is caused by, contributed to by or results from a Preexisting Condition. The Preexisting Condition exclusion will not apply after you perform the material duties of your Regular Occupation for at least 12

consecutive months following your effective date of coverage or following the effective date of any increased benefit amount option.

Your Cost for Coverage

See your enrollment materials for any contribution amounts that may be required.

When Coverage Ends

Your coverage will end at 12:00 midnight on the earliest of the following:

- On the date that the Plan terminates or your Employer withdraws from the Plan
- On the date that you cease to be in an Eligible Class
- On the last day for which you or your Employer made any required contributions
- On the date your employment ends
- On the date that your Plan benefit ceases, if you do not return to Active Work. If you return to Active Work as an eligible Employee after a particular Disability ceases, you will continue to participate in the Plan. Benefits for certain subsequent Disabilities are described in the Recurrent Disabilities section of this SPD. If you have questions about your eligibility to participate when you return to Active Work, contact the Plan Administrator.

Notwithstanding the foregoing, based on the Employer's employment policies, coverage may continue during leaves of absence, sabbaticals, or other periods defined in the Employer's employee handbook or policy manual.

Section 2: Plan Benefits

Applying for Benefits

Details on applying for benefits can be found in the Filing a Claim section of this SPD. The determination as to whether you are eligible for Plan benefits is made on the basis of your eligibility on the last day you were Actively at Work.

When Benefits Begin

Your benefits will begin to be paid to you after you complete the Elimination Period as shown on the Plan Outline.

Accumulation of the Elimination Period

As noted above, you must complete the Elimination Period before any Benefit is payable. For the purpose of accumulating the Elimination Period, the following rules apply:

- During the Elimination Period, a total Disability that temporarily ceases for not more than 30 days, whether consecutive or intermittent, will be considered continuous for the purpose of accumulating the Elimination Period. Any days that you are not Disabled will not be counted toward completion of the Elimination Period
- If, during the Elimination Period, you become eligible for coverage or insurance under any other group long-term disability plan/policy, the terms of the above paragraph will not apply.

Payment of Benefits

Benefits will be paid to you in accordance with the Plan Outline provided that you remain Disabled and submit proof of continued Disability, at your expense, upon request. In addition, you may be required to

undergo an independent medical exam at reasonable intervals at the Plan's expense.

When Benefits End

Disability benefit payments will end when any of the following occurs:

- You no longer are under the care of a Licensed Physician, or you are not receiving regular, ongoing medical care, or you are not following the course of treatment recommended by a Licensed Physician
- You complete the Maximum Benefit Duration period
- You no longer satisfy the Plan's definition of Disability
- You no longer comply with the terms of the Plan
- A Licensed Physician no longer verifies your Disability
- You fail to furnish proof of Disability satisfactory to the Claims Administrator, you fail to submit required documentation of or medical information about your Disability, or you refuse to undergo a medical examination upon request
- You take full- or part-time employment with another employer or work for a self-owned or family-owned business
- You die.

Waiver of Contributions

If you contribute toward the cost of benefits under this Plan, contributions normally required by you are waived during any period of total Disability for which you receive, or are eligible to receive, benefits under this Plan. If your contributions have been waived during your total Disability, you may resume contributions if you do so within 30 days following your return to Active Work, if you continue to meet the eligibility and other requirements of the Plan.

Benefit Amount

The amount of your benefit shall be:

- the lesser of: (1) your Basic Monthly Earnings multiplied by the benefits percentage specified in the Plan Outline, or (2) the dollar amount of the Maximum Monthly Benefit shown in the Plan Outline,
- reduced by Other Income Benefits described below. After the initial determination of Other Income Benefits, your Monthly Benefit will not be further reduced because of any cost-of-living increases under the Other Income Benefits.

The amount of the benefit, plus any rehabilitation pay you may earn while Disabled, cannot exceed your Basic Monthly Earnings. If this happens, your benefit will be reduced by the amount in excess of your Basic Monthly Earnings.

To the extent required by law, income and employment taxes will be withheld on all benefit payments.

Other Income Benefits

Other Income Benefits are those benefits identified below, which are applicable to you. These Other Income Benefits, are benefits associated with the same or a different Disability for which a Benefit is payable under the Plan. These other Income Benefits include:

- The full amount provided to you pursuant to any Workers' Compensation law, occupational disease law, or any other legislation or law of similar purpose.
- The full amount of disability income benefits you receive or are eligible to receive under any present or future law. This includes any amount that is not received solely because you failed to apply for it.

- The full amount of any disability income benefits which you receive under any other group insurance or individual policy paid for or subsidized by your Employer.

- The full amount of disability or retirement benefits under the US Social Security Act or any other governmental disability or retirement program (except military pension and military disability plans) for which you, your spouse, child or children are eligible. Notwithstanding the foregoing, Other Income Benefits shall not include disability benefits unless such disability benefits are awarded on the basis of your disability.

- The full amount of any no-fault motor vehicle coverage. However, benefits from such coverage will not be included as Other Income Benefits if:

- 1) State law or regulation does not allow any reduction of disability benefits by benefits received under no-fault motor vehicle coverage, or

- 2) The no-fault motor vehicle coverage, according to its rules or according to an election by the person covered, determines its benefits after the Benefits paid or due under this Plan have been paid.

- Except with respect to the section below entitled "Rehabilitative Employment," the full amount of any salary, wages, severance, benefits, commissions, bonuses, accrued sick days, vacation days, holidays or similar pay that you receive or are entitled to receive from any work or services in which you engage.

- The full amount of any payments that you receive or are eligible to receive due to the acts of third parties who, in the Plan's determination, are at least partially responsible for your claim for benefits under the Plan. This includes any payments that are obtained through the pursuit of claims, lawsuits, judgments, awards, and settlements

or otherwise by you or by any person or entity on your behalf.

- The full amount of any Retirement Disability Benefits you receive under a Retirement Plan sponsored by Ascension Health or any of its affiliated health ministries.
- The full amount of any benefit or compensation for which you are eligible or that is paid to you, or a third party on your behalf, pursuant to any plan or arrangement, whether insured or not, as a result of employment by or association with your Employer or as a result of membership in or association with any group, association, union or other organization.

Other Income Benefits includes any amount you could receive but are not receiving because you failed or neglected to make application for such.

The Plan's share of these Other Income Benefits will not be reduced because you have not received full damages claimed or have not been made whole, unless the Claims Administrator or the Plan Administrator agrees in writing to the reduction. The Plan's share of these Other Income Benefits will not be reduced by any attorney's fees or costs expended by you in obtaining the Other Income Benefits.

The terms "law", "Plan" or "act" include the initial enactment and all amendments.

Lump Sum Payments/Settlements

If any Other Income Benefits are paid (either as money, property or annuity) through a settlement, judgment, order, or as an advance on future liability in a lump sum, the amount that pertains to Other Income Benefits will be due and payable immediately, unless the Claims Administrator or the Plan Administrator agrees in writing to a different repayment schedule.

Refund to the Plan for Overpayment of Benefits

If at any time the Claims Administrator or the Plan Administrator determines that the total amount paid to you on a claim is more than the total amount due, including but not limited to any overpayment resulting from any payment you receive from sources listed as Other Income Benefits (whether through lawsuit, pursuit of claims, settlement, award, judgment or otherwise), the Claims Administrator or the Plan Administrator has the right to recover the excess amount from you. The Claims Administrator or the Plan Administrator may recover the excess amount by reducing or offsetting against any future benefits payable to you by demanding immediate reimbursement, or by any other method permitted by law.

Death of Claimant

If you die, any unpaid benefits due will be paid to your surviving spouse. If you have no surviving spouse, benefits will be paid to your estate.

Rehabilitative Employment

If you are Disabled from your Regular Occupation but accept Rehabilitative Employment approved by the Claims Administrator, your benefit percentage will be increased by 5%. During the first 24 months of benefit payments, the Plan will not offset earnings you received during approved Rehabilitative Employment, up to 100% of your pre-Disability Basic Monthly Earnings. After you have completed 24 months of work or service while Disabled, your benefit will be reduced by 50% of any compensation earned. Upon request you must provide evidence needed to verify your earnings.

In addition to long-term Disability payments, the Plan will pay for coordination with your Employer, the Plan Administrator

and the Claims Administrator to assist you to return to work, evaluation of adaptive equipment to allow you to return to work, vocational evaluation to determine how your Disability may impact your employment options, job placement services, résumé preparation, job seeking skills, and training or re-training for a new occupation.

Child Care Expense Benefit

While you are Disabled and participating in a Rehabilitative Employment approved by the Claims Administrator, you will be reimbursed for child care expenses of up to \$250 of incurred expenses per month for each eligible child during the first 24 months of Rehabilitative Employment.

Child care expense is limited to the amount charged by a licensed child care provider who is not a member of your immediate family or living in your residence.

An eligible child is your dependent child under age 13 who lives with you and is:

- Your child or your spouse's child
- Your legally adopted child *or*
- A child for whom you are the legal guardian.

Recurrent Periods of Disability

If, following a period of Disability for which benefits are payable, you resume your Regular Occupation and perform all Material Duties full time for a continuous period of six months or more, any Recurrent Disability will be considered a new period of Disability and another Elimination Period must be completed before any further benefits are payable.

If you resume your Regular Occupation for less than six months, a Recurrent Disability will be considered a continuation of the same Disability and no elimination period is required. Therefore, you would not be eligible to file a Short Term Disability claim

for the Recurrent Disability. The Plan's liability for the entire period will be subject to the provisions of this Plan for the original period of Disability. Your benefit amount will be reinstated and the previous period of disability would apply toward benefit durations.

If you become eligible for coverage under any other group long-term disability policy or plan, this Recurrent Disability provision will no longer be applicable to you.

Mental Illness Limitation

To be eligible for Disability benefits related to Mental Illness, you must be under the regular care and attendance of a licensed practicing psychiatrist. While you are Disabled due to a Mental Illness and confined to a Hospital or Institution (for 24 hours a day), the benefit will be payable up to the Maximum Benefit Duration. In patient days will not apply against the 24 months mental nervous provision.

While you are Disabled due to a Mental Illness but not confined to a Hospital or Institution, the benefit will be payable for up to 24 months or the Maximum Benefit Duration, whichever is less.

In no event will the Benefit be payable for longer than the Maximum Benefit Duration Period during a period of continuous Disability due to Mental Illness, whether you are or are not confined to a Hospital or Institution for such condition.

Section 3: Other Plan Provisions

Social Security Disability Benefits

If it is unlikely that you will be able to return to work for at least 12 months, you also may be eligible to receive Social Security disability payments. There are four major advantages to receiving Social Security Administration disability payments:

1. Cost-of-living increases will not result in an offset under this Plan. Thus, you will experience increased income from the combination of benefits from this Plan and Social Security benefits.
2. Twenty-four months after your Social Security disability award date, you automatically will be eligible for free Medicare hospital insurance and, for a small monthly premium, Medicare Part B insurance. Other Medicare options also may be available to you such as Medicare Part C (Medicare Advantage) and Medicare Part D (prescription drug coverage).
3. The Social Security disability freeze allows your wage record to be “frozen” and prevents future retirement benefits from being reduced. (Disability periods not recognized by Social Security can adversely affect your record of average monthly earnings as well as your fully or currently insured status used later for Social Security benefit determination.)
4. Your Employer-provided Ascension Health Retirement Plan will continue to accrue credited service during your Disability for the Disability period recognized by your Social Security disability award if you meet the requirements of your Employer-sponsored Ascension Health Pension Plan.

Social Security disability payments begin after a five-month waiting period and are the same amount as Social Security retirement benefits for an individual at age 65. An additional benefit equal to 50% of your Social Security benefit amount may be payable to your spouse and to each dependent child who is under age 18 or who is totally and permanently disabled. There is a maximum limit on the amount a family can receive.

After four months of continuous Disability, you should contact your nearest Social Security office to apply for Social Security disability benefits.

- An estimated Social Security disability offset may be subtracted from your benefit under this Plan even if you have not applied for such benefits (but it appears that you would qualify for them).

In any case, when you do receive approval or final denial of your claim from the Social Security Administration, your benefit will be adjusted and you must promptly refund all Plan overpayments. If the Social Security Administration does not declare you eligible for Social Security disability benefits, there will be no offset from your benefits unless you are age 62 or older. If you are age 62 or older, an estimated primary Social Security retirement offset will be made from your Disability benefit even if you have not applied for Social Security retirement benefits.

General Exclusions

This Plan does not provide benefits for:

- That portion of any period of Disability when you are confined in any penal or correctional institution as a result of conviction for criminal or other public offense
- Any Sickness or Injury for which:

- you are not receiving ongoing medical care from a Licensed Physician *or*
- you are not following the course of treatment recommended by a Licensed Physician
- Disabilities caused or contributed to by:
 - war, whether declared or undeclared, or any act of war, insurrection, civil commotion, rebellion or riot
 - a Sickness contracted or Injury sustained while in the armed forces of any country engaged in war or other armed conflict
- Disabilities resulting from:
 - intentionally self-inflicted injury of any kind, while sane or insane
 - participating in, or as a result of having participated in, the commission of an assault or felony
 - cosmetic surgery
 - elective abortion for any reason
 - voluntary sterilization including resection, transection, or ligation of tubes
 - procedures or services that are in conflict with the Ethical and Religious Directives for Catholic Health Care Services or Catholic Church Teachings.
- Any period that you are on personal, educational or military leave of absence, on layoff or disciplinary suspension, except as may otherwise be provided in your Employer's policies
- Any Disability that began after your employment terminated

Preexisting Condition Exclusion

The Plan does not provide benefits for any Disability that is caused by, contributed to by, or results from a Preexisting Condition that was in existence within three months before your effective date of coverage. The Preexisting Condition exclusion will not apply after you perform the Material Duties of your Regular Occupation for at least 12

consecutive months following your effective date of coverage or following the effective date of any increased benefit amount option.

If your benefit coverage increases because you elect another benefit amount option, you elect coverage when you do not have any just prior to the effective date, or because you change Eligible Classes, the increased amount will be subject to this Preexisting Condition exclusion at the time the change in coverage becomes effective.

General Provisions

- No Benefit under this Plan shall provide paid-up insurance or loan cash values
- No agent has the authority to accept or waive the required notice or proof of a claim, or to extend the time within which a notice or a proof must be given
- You will not receive long-term Disability benefits for the same time period that short-term Disability plan benefits are paid
- You will not be eligible for benefits under this Plan if your employment has been terminated prior to becoming Disabled
- You may not assign any present or future benefit to another person.

Discretionary Authority

In carrying out their respective responsibilities under the Plan, the Plan Administrator and the Claims Administrator shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan.

Section 4: Filing a Claim

Applying for Benefits

You must notify your Employer within the time period (either 45 or 90 days) specified in the Plan Outline. The notification period is 90 days after the Disability if the Employer elected a 180-day Elimination period and 45 days after the Disability if the Employer elected a 90-day elimination period.

You must file your claim with the Claims Administrator prior to the close of the applicable Elimination Period. Failure to file your claim before the close of the Elimination Period will result in denial of benefits.

Claim Forms

You must complete all forms required by your Employer, the Plan Administrator and/or the Claims Administrator in order for your claim to be considered.

Medical Examination and Vocational Assessment

The Claims Administrator may require you to undergo an examination by a doctor selected by the Claims Administrator or a vocational assessment by a vocational counselor selected by the Claims Administrator at reasonable intervals after your claim has been submitted. The Claims Administrator also may require you to submit additional information before your claim is processed.

Determination of Benefits

After your claim has been processed, you will be notified of any benefits due. If you have any questions about a claim payment, contact the Claims Administrator. Contact

information is provided in the Plan and Contact Information section of this SPD.

The Claims Administrator will notify you of its benefit determination within 45 days after receipt of the claim. This period may be extended for up to 30 days if an extension is necessary due to matters beyond the control of the Plan. If such an extension of time is taken, the Claims Administrator will notify you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days. If such an additional extension of time is taken, the Claims Administrator will notify you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which a decision is expected to be rendered.

The notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve those issues. You will have 45 days after receipt of the notice to submit any additional information that is requested in the notice.

Every notice of an adverse benefit determination will be provided in writing or electronically and will include the following:

- The specific reason or reasons for the adverse determination
- Reference to the specific Plan provisions on which the determination is based
- A description of any additional material or information necessary to perfect the

- claim and an explanation of why such material or information is necessary
- A description of the Plan’s review procedures and the time limits applicable to such procedures
- If an internal rule, guideline, protocol or other similar criterion (“Internal Guideline” is relied upon in making the adverse determination, either the Internal Guideline or a statement that the Internal Guideline was relied upon in making the adverse determination and a copy of the Internal Guideline will be provided free of charge to you upon request *and*
- The name of any medical or vocational expert whose advice was obtained in connection with an adverse benefit determination.

You are entitled to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Appeal of Adverse Benefit Determination

You are entitled to file an appeal within 180 days after you receive notice of an adverse benefit determination.

Appeals should be submitted to and will be reviewed by the Claims Administrator at the address listed in “Section 6: Plan and Contact Information” of this SPD.

You may submit written comments, documents and other information with your appeal. The review will take your comments, documents or other information into account, whether or not they were considered in the initial determination.

You may receive, upon request and free of charge, reasonable access to and copies of Summary Plan Description for the Ascension Health Long-Term Disability Plan

all documents, records and other information relevant to your claim for benefits.

The review will not give deference to the initial determination, and it will be conducted by an individual who is neither the individual nor a subordinate of the individual who made the initial determination.

In deciding the appeal of an adverse determination that is based on a medical judgment, the Claims Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. This health care professional will be neither the individual nor a subordinate of the individual who was consulted during the initial determination.

As part of the claim review procedure, the Claims Administrator may require you to undergo an examination by a doctor of its choice and/or a vocational assessment by a vocational counselor of its choice.

The Claims Administrator will notify you of the benefit determination on review within 45 days after receipt of your request for review, unless special circumstances require an extension of time for processing the claim. If such an extension of time is required, you will be notified in writing of the extension prior to the end of the initial 45-day period. No such extension will exceed a period of 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator or its representative expects to render the determination on review.

Notice of the decision on review will be provided in writing or electronically and will include the following:

- The specific reason or reasons for the adverse determination
- Reference to the 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, a copy of any documents, records or other information that is relevant to your claim, as well as any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination. You also are entitled to receive an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit, and identification of any medical or vocational experts whose advice the Claims Administrator relied on.

Prior to bringing any action relating to or arising under the Plan, you must exhaust your administrative remedies under the Plan, which means that you must file a timely application for benefits and a timely appeal if that application for benefits is denied.

You also have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if you are not satisfied with the decision on review. You and the appeal administrator may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

All claims for benefits and requests for review of claim denials should be submitted to the Claims Administrator at the address listed in the Plan and Contact Information section of this SPD.

Misrepresentations

The Plan reserves the right to take appropriate legal action against any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Plan, submits an application or files a claim containing a false, incomplete or misleading statement.

Section 5: Your ERISA Rights

The Plan is subject to the Employee Retirement Income Security Act of 1974 (“ERISA”). As a participant in this Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit. In 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in 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 Plan Administrator or Claims 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

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

Exhaustion of Administrative Remedies and Forum Selection Clause

You are required to exhaust all administrative remedies available under this Plan before bringing any action relating to or arising under this Plan. This exhaustion requirement applies to claims arising under Section 502 of ERISA as well as any other Section of ERISA.

The Plan contains a forum selection clause, which requires that any action relating to or arising under this Plan shall be brought in and resolved only in the U.S. District Court for the Eastern District of Missouri, and in any courts in which appeals from such court are heard.

Section 6: Plan and Contact Information

Official Plan Name	Ascension Health Long-Term Disability Plan (Amended and Restated as of January 1, 2006)
Employer Identification Number	31-1662309
Plan Number	512
Plan Description	Long-Term Disability Plan
Plan Sponsor and Administrator	Ascension Health 4600 Edmundson Road St. Louis, MO 63134 (314) 733-8000
Trustee	State Street Bank and Trust Company P.O. Box 1992 Boston, MA 02105-1992
Type of Administration	The Plan is jointly administered by the Plan Administrator and the Claims Administrator.
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) 733-8000
Type of Funding	Employer and employee contributions are held in trust to pay expenses and Plan benefits.
Contact Information	
To File a Claim	Claims Administrator Sedgwick Claims Management Services, Inc. P.O. Box 14562 Lexington, KY 40512 Phone: (866) 856-4835; FAX: (314) 514-2374
To Appeal a Claim	Sedgwick Claims Management Services, Inc Attn: National Appeals Unit P. O. Box 14446 Lexington, KY 40512-9951 Phone: (800) 248-3970; FAX: (888) 488-9536

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