



ASSURANT
Employee
Benefits

Group Benefits

St. Francis Health Services of Morris, Inc.

Voluntary Long Term Disability

**CERTIFICATE OF
GROUP INSURANCE**

Union Security Insurance Company certifies that the insurance stated in this Certificate became effective on the Effective Date shown in your Schedule. This Certificate is subject to the provisions of the below numbered *policy* issued by Union Security Insurance Company to the *policyholder*.

Policyholder: St. Francis Health Services of Morris, Inc.

Group Policy Number: 4054637

Participation Number: 0

Effective Date: For any *period of disability* starting on or after January 1, 2015.

This Certificate replaces any and all Certificates and Certificate Endorsements, if any, issued to you under the *policy*.

A handwritten signature in black ink that reads "Joe Roberts". The signature is written in a cursive style with a large, looping initial "J".

President and
Chief Executive Officer

SCHEDULE

Eligible Persons

To be eligible for insurance, a person must be a member of an Eligible Class. The person must also complete a period of continuous service (Service Requirement) with the *policyholder* (or any *associated company*).

Eligible Class: Each *full-time* employee of the *policyholder* or an *associated company*,

- whose *monthly pay* is greater than or equal to \$1,000, and
- who is at *active work*, and
- who is working in the United States of America,

as identified on the *policyholder's* or our records, except any temporary or seasonal worker.

Associated Companies:

Aitkin Health Services
Browns Valley Health Center
Chisholm Health Center
Farmington Health Services
Franciscan Health Center
Guardian Angels Health & Rehabilitation Center
Little Falls Health Services
Pennington Health Services
Prairie Community Services
Renville Health Services
Viewcrest Health Center
West Wind Village
Zumbrota Health Services

Service Requirement: 60 days

Entry Date

Insurance will take effect on the later of (i) the date shown below, and (ii) the first of the month occurring on or after the day all the eligibility requirements are met.

Effective Date of Insurance

For *periods of disability* starting on or after January 1, 2015 (subject to Entry Date)

Long Term Disability Insurance

Schedule Amount: The Schedule Amount is the amount you elected. The Schedule Amount may not be more than 60% of *monthly pay*, must be in \$100 units, subject to a minimum Schedule Amount of \$500 and a maximum Schedule Amount of \$5,000 per month, except as stated in Proof of Loss provision. The amount will be rounded to the nearest multiple of \$100, if not already an exact multiple. However, the maximum Schedule Amount may exceed 60% of *monthly pay* after the rounding is applied.

You may elect to change your Schedule Amount, subject to the above limits, during each October 13 through December 1, the annual enrollment period agreed upon by the *policyholder* and us. The new Schedule Amount will be effective on the next following policy anniversary. The amount of any increase is subject to a pre-existing conditions period, as described in the "Long Term Disability Insurance" provisions of the *policy*. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the effective date of your coverage.

For each day of a period less than a full month, the Schedule Amount will be 1/30th of the amount determined above.

Monthly pay must be from the *policyholder* or an *associated company*, is determined on the day before the *period of disability* starts, and means 1/24th of the sum of:

- taxable income, and

SCHEDULE (continued)

- the amount of any pre-tax income deferrals the person has elected to have withheld through salary reduction,

as reported on the United States Treasury Department Wage and Tax Statements Forms W-2 for the 2 calendar years occurring before the *period of disability* starts. If the person has been employed for less than 2 calendar years, *monthly pay* will be a monthly average of the amount appearing on such form(s).

During the calendar year in which the person became employed by the *policyholder* or an *associated company*, we will not use Form W-2. *Monthly pay* means the person's current *monthly pay*, including the amount of any pre-tax income deferrals the person has elected to have withheld through salary reduction, on the day before the *period of disability* starts. Bonuses, overtime, and other compensation not considered by us as basic wages or salary are not included. However, any commissions received will be included, based on a monthly average of commissions received during the time the person was eligible to receive them.

Plan Changes

You may change your plan of insurance within 31 days after a change in family status. The effective date of the change will be the first of the month occurring on or after the date of the request. A "change in family status" means your marriage or divorce, the death of your spouse or child, the birth or adoption of your child, the termination of your spouse's employment, or any other event specified in the *policyholder's* IRC Section 125 plan, if any. The amount is subject to a pre-existing conditions period, as described in the "Long Term Disability Insurance" provisions of the *policy*. The effective date will be the date you became insured for the purpose of determining the pre-existing conditions period.

Minimum Benefit: If you normally work at least 30 hours per week before your *period of disability* starts, the minimum monthly benefit will be \$100. For any part of a *period of disability* less than a full month, the Minimum Benefit is 1/30th of \$100 for each day of *disability* after the *qualifying period* ends.

Qualifying Period:

- For a *covered person* insured under the *policyholder's* Short Term Disability plan, if any benefits are payable under the Short Term Disability plan for the Maximum Benefit Period and the period of disability for Short Term Disability benefits did not result from a Pre-Existing Condition, the *qualifying period* is the Maximum Benefit Period for the Short Term Disability plan; or
- For a *covered person* insured under the *policyholder's* Short Term Disability plan, if any benefits are payable under the Short Term Disability plan for the Maximum Benefit Period and the period of disability for Short Term Disability benefits did result from a Pre-Existing Condition, the *qualifying period* is 6 months or
- In all other cases, the *qualifying period* is 6 months.

Maximum Interruption During Qualifying Period: 6 months

This Maximum applies to all returns to *active work* during any one *qualifying period*. However:

- the *qualifying period* will not be considered interrupted while you are in a *period of disability* under the Short Term Disability Policy; and
- the "Maximum Interruption During Qualifying Period" provision applies only to *periods of disability* when benefits are not payable under the Short Term Disability Policy.

Maximum Benefit Period: We will not pay benefits beyond the later of (a) the day before you reach age 65 or (b) 24 months of *disability* following the end of the *qualifying period*.

TABLE OF CONTENTS

GENERAL DEFINITIONS	2
DEFINITIONS FOR LONG TERM DISABILITY INSURANCE	3
ELIGIBILITY AND TERMINATION PROVISIONS	8
Exception to Effective Date	8
When Your Insurance Ends.....	8
LONG TERM DISABILITY INSURANCE	9
Insurance Provided.....	9
Amount of Benefit	9
Offset Amount.....	9
Estimate of Benefits or Other Amounts	10
Social Security Assistance	10
Adjustment of Benefits.....	11
Lump Sum Benefit	11
Benefit Freeze	11
Rehabilitation Benefit.....	11
Exclusions.....	12
Special Conditions.....	13
Pre-Existing Conditions	13
Extended Benefit	14
Conversion Privilege.....	14
Survivor Benefit	14
CLAIM PROVISIONS.....	15
Payment of Benefits	15
To Whom Payable	15
Authority.....	15
Filing a Claim	15
Proof of Loss	15
Right to Examine or Interview	16
Limit on Legal Action	16
Review Procedure	16
Incontestability	16
GENERAL PROVISIONS.....	17
Entire Contract.....	17
Errors	17
Misstatements	17
Certificates.....	17
Workers' Compensation	17
Agency.....	17
Fraud	17

GENERAL DEFINITIONS

These terms have the meanings shown here when *italicized*. The pronouns "we", "us", "our", "you", and "your" are not *italicized*.

Active work means the expenditure of time and energy for the *policyholder* or an *associated company* at your usual place of business on a *full-time* basis. If you are working on the day your coverage would otherwise take effect, you will be considered to be at *active work* on that day only if, when your work begins on that day, it would be reasonable to expect that you would be physically and mentally able to complete a *full-time* week of work in your *regular occupation*.

Associated company means any company shown in the *policy* which is owned by or affiliated with the *policyholder*.

Contributory means you pay part or all of the premium.

Covered person means an eligible employee or member of the *policyholder*, or an *associated company* who has become insured for a coverage.

Doctor means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. Also, a person whom we are required to recognize as a *doctor* by the laws or regulations of the governing jurisdiction, or a person who is legally licensed to practice psychiatry, psychology or psychotherapy and whose primary work activities involve the care of patients, is a *doctor*. However, neither you nor a *family member* will be considered a *doctor*.

Eligible class means a class of persons eligible for insurance under the *policy*. This class is based on employment or membership in a group.

Family member means a person who is a parent, spouse, child, sibling, domestic partner, grandparent or grandchild of the *covered person*.

Full-time means working an average of at least 56 hours per pay period, unless indicated otherwise in the *policy*.

Home office means our office in Kansas City, Missouri.

Injury means accidental bodily injury. It does not mean intentionally self-inflicted injury while sane or insane.

No-fault motor vehicle coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident that occurs.

Policy means the group policy issued by us to the *policyholder* that describes the benefits for which you may be eligible.

Policyholder means the entity to whom the *policy* is issued.

Proof of good health means evidence acceptable to us of the good health of a person.

We, us, and our mean Union Security Insurance Company.

You and your mean an eligible employee or member of the *policyholder* or an *associated company* who has become insured for a coverage.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE

Accommodation expense means the costs your employer incurs to accommodate your *disability*, as required by the Americans with Disabilities Act or similar legislation. It also means costs you incur for tools, equipment, furniture, computer software, or other items necessary for you to return to work. The amount of the *accommodation expense* will be limited to \$3,000 for each *period of disability*.

Contagious disease means the asymptomatic but communicable conditions, Hepatitis B that is surface antigen positive, Human Immunodeficiency Virus (HIV), and multidrug-resistant Tuberculosis as defined by the Centers for Disease Control and Prevention.

Disabled or disability means that you satisfy the Occupation Test or Contagious Disease Test, as described below. You must have experienced a significant change in your condition while insured under the *policy* to be considered *disabled*.

Occupation Test

- During the *qualifying period* and the following 24 months of a *period of disability*, an *injury*, sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least one of the *material duties* of your *regular occupation*; and
- after the *qualifying period* and the first 24 months of *disability*, an *injury*, sickness, or pregnancy prevents you from performing at least one of the *material duties* of each *gainful occupation* for which your education, training, and experience qualifies you.

The inability to perform a *material duty* because of the discontinuance of *reasonable accommodation(s)* on the part of the employer does not, in itself, constitute *disability*.

Contagious Disease Test

If you are capable, physically and mentally, of performing the *material duties* of your own *occupation*, but your ability to perform these duties has been restricted:

- by a state licensing board or by another appropriate government authority; and
- because of the risk of transmission of a *contagious disease* to others with whom you may come in contact;

you may also be considered *disabled* during the *qualifying period* and the following 24 months of a *period of disability* in any month in which you have a *contagious disease*.

Education expense means, in your *rehabilitation plan*, the reasonable costs you incur which are required for your education or training to return to work. These costs may include the cost of tuition, books, computers, and other equipment. In your spouse's *rehabilitation plan*, *education expense* means the reasonable costs your spouse incurs which are required for your spouse's education or training. These costs may include the cost of tuition, books, computers, and other equipment.

Family care expense means the amount you spend for care of a family member in order for you to work or be retrained under a *rehabilitation plan*. To qualify:

- your family member must be under age 13, or be physically or mentally incapable of caring for him or herself;
- your family member must be dependent on you for support and maintenance; and
- the person who cares for your family member cannot be a relative.

Not more than \$350 per family member per month will be included. A pro-rated amount will apply to any period shorter than a month.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

Gainful occupation means an *occupation* in which you could reasonably be expected to earn at least as much as your Schedule Amount within 12 months of your return to work.

Government plan means the United States Social Security Act, the Railroad Retirement Act, the Canadian Pension Plan, similar plans provided under the laws of other nations, and any plan provided under the laws of a state, province, or other political subdivision. It also includes any public employee retirement plan or any teachers' employment retirement plan, or any plan provided as an alternative to any of the above acts or plans. It does not include any Workers' Compensation Act or similar law, or the Maritime Doctrine of Maintenance, Wages, or Cure.

Hospital means a facility supervised by 1 or more *doctors* and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

Hospital confined or *hospital confinement* means staying in a *hospital* for 24 hours a day and it must be medically necessary according to *nationally recognized authorities*.

Intoxication or *intoxicated* means your blood alcohol level exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Long term disability insurance means the group long term disability insurance under the *policy* issued by us to the *policyholder*.

Material duty or *material duties* means the sets of tasks or skills required generally by employers from those engaged in an *occupation*, which cannot be reasonably accommodated. We will consider one *material duty* of your *regular occupation* to be the ability to work for an employer on a *full-time* basis as defined in the *policy*. However, if a *material duty* of your *regular occupation* is to work more than 40 hours per week, we will consider you able to perform that *material duty* if you have the capacity to work at least 75% of those hours per week. In addition, no duty will be considered a *material duty* of your *regular occupation* if you were not able, as a result of *injury*, sickness, or pregnancy, to perform that duty with reasonable consistency at the time you became a *covered person* or entered that *occupation*, if later.

Maximum capacity means the full utilization of your capabilities in any *occupation* that you are able to do.

Medical expense means the reasonable costs you incur for medical treatment, physical therapy, and adaptive equipment necessary for your vocational rehabilitation, in excess of amounts paid or payable by third parties and any amounts under a policy of major medical coverage.

Mental illness means a mental disorder as listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association. A *mental illness*, as so defined, may be related to or be caused by physical or biological factors, or result in physical symptoms or expressions. For the purposes of the *policy*, *mental illness* does not include any mental disorder listed within any of the following categories found in the Diagnostic and Statistical Manual of Mental Disorders, as published by the American Psychiatric Association:

- Mental Retardation;
- Motor Skills Disorder;
- Pervasive Developmental Disorders;
- Delirium, Dementia, and Amnesic and other Cognitive Disorders;
- Schizophrenia; and
- Narcolepsy, Obstructive Sleep Apnea, and Sleep Disorder due to a general medical condition.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

Moving expense means the costs you incur to move more than 35 miles so that you can attend school or accept gainful work. In a spouse's *rehabilitation plan*, the costs are those incurred by the family so that the spouse can attend school or accept gainful work.

Nationally recognized authorities means the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, and any additional organizations we choose which attain similar status.

Occupation means a group of jobs or related jobs:

- in which a common set of tasks is performed; or
- which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

Other plan means any group disability plan sponsored by your employer, the *policyholder*, or an *associated company*, except the one provided under the *policy*.

Period of disability means the time that begins on the day you become *disabled* and ends on the day before you return to *active work*. If you satisfy the *qualifying period* and then:

- return to *active work*;
- become *disabled* again; and
- remain insured under the *policy*;

the same *period of disability* may continue. Your return to *active work* must be for less than:

- 6 months, if the later *disability* results from the same cause, or a related one; or
- 1 day, if the later *disability* results from a different cause.

If your return to *active work* meets either of the above conditions, you do not have to satisfy the *qualifying period* again. The Maximum Benefit Period will continue on the day you become *disabled* again.

If you return to *active work* for more than the time shown above, and then become *disabled* again, you will start a new *period of disability*. You must satisfy the *qualifying period* again and the Maximum Benefit Period will start over.

Qualifying period means the length of time during a *period of disability* that you must be *disabled* before benefits are payable. If you satisfy the Contagious Disease Test during the entire *qualifying period*, the Maximum Interruption During Qualifying Period in the Schedule will not apply. If application of the Occupation Test and the Maximum Interruption During Qualifying Period would result in an earlier entitlement to benefits, we will apply those provisions instead of the Contagious Disease Test. In satisfying the Occupation Test, if you:

- return to *active work* during the *qualifying period* for no more than the maximum shown in the Schedule;
- remain insured under the *policy*; and
- become *disabled* again for the same cause or one related to it;

you will not have to satisfy again the part of the *qualifying period* that you have already fulfilled.

In any case, you cannot satisfy any part of the *qualifying period* by any *period of disability* that results from a cause for which we do not pay benefits.

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

Any days of *active work* (including weekends in between) will not count in satisfying the *qualifying period*.

Reasonable accommodation(s) means any modification(s) to the worksite, the job or employment practices, which would allow you to perform the *material duties* of the *occupation* and which would not create an undue hardship for the employer.

Regular care and attendance means care by a *doctor* at a frequency medically appropriate to effectively treat and manage your condition. You must be receiving the most appropriate treatment and care which conforms with generally accepted medical standards by a *doctor* whose specialty or experience is the most appropriate for your condition.

Regular occupation means the *occupation* in which you were working immediately prior to becoming *disabled*.

Rehabilitation plan means a written agreement between you and us in which, at your request, we agree to provide, arrange, or authorize appropriate vocational or physical rehabilitation services.

A spouse's *rehabilitation plan* means a written agreement between you, your spouse, and us in which, at your request, we agree to provide, arrange or authorize appropriate vocational or physical rehabilitation services.

Retirement plan means a formal or informal retirement plan, whether or not under an insurance or annuity contract. It does not include:

- a plan you pay for entirely;
- a qualified profit-sharing plan;
- a thrift plan;
- an individual retirement account (IRA);
- a tax sheltered annuity (TSA);
- a stock ownership plan;
- a *government plan*; or
- a plan that qualifies under Internal Revenue Service Code 401(k).

Social security plan means:

- the United States Social Security Act;
- the Railroad Retirement Act;
- the Canadian Pension Plan; or
- any similar plan provided under the laws of any other nation.

It also means any public employee retirement plan, or teachers' employment retirement plan provided as an alternative to rather than a supplement for such plans.

SSA representatives are persons or organizations which specialize in assisting people to obtain disability benefits under the United States Social Security Act. If you appoint an *SSA representative*, and they agree you are a good candidate, they will help you pursue your Social Security claim.

Special conditions means:

- *mental illness*;

DEFINITIONS FOR LONG TERM DISABILITY INSURANCE (continued)

- musculoskeletal and connective tissue disorders of the neck and back including any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue including sprains and strains of joints and adjacent muscles, except
 - arthritis;
 - herniated intervertebral discs;
 - scoliosis;
 - spinal fractures;
 - osteopathies;
 - spinal tumors, malignancy, or vascular malformations;
 - radiculopathies, documented by electromyogram;
 - spondylolisthesis, grade II or higher;
 - myelopathies and myelitis;
 - demyelinating diseases; or
 - traumatic spinal cord necrosis.
- chronic fatigue syndrome;
- fibromyalgia;
- carpal tunnel syndrome;
- environmental allergic illness, including but not limited to sick building syndrome and multiple chemical sensitivity; or
- alcohol abuse, dependency or addiction.

ELIGIBILITY AND TERMINATION PROVISIONS

Exception to Effective Date

If you are not at *active work* on the day you would otherwise become insured, your insurance will not take effect until you return to *active work*. If the day your insurance would normally take effect is not a regular work day for you, your insurance will take effect on that day if you are able to do your regular job.

When Your Insurance Ends

Your insurance will end on the date:

- the *policy* ends;
- the *policy* is changed to end the insurance for your *eligible class*;
- you are no longer in an *eligible class*;
- you stop *active work*; or
- a required contribution was not paid.

LONG TERM DISABILITY INSURANCE

Insurance Provided

If you become *disabled* while insured under the *policy*, we will pay long term disability benefits if you satisfy the *qualifying period*. We will continue to pay benefits during your *disability*, but not beyond the Maximum Benefit Period. Any benefits are subject to the provisions of the *policy*.

Amount of Benefit

The amount of benefit we will pay is the Schedule Amount minus the Offset Amount. However if the Schedule Amount plus the amount of benefits and payments from the Offset Amount is more than 100% of your *monthly pay*, your benefit will be further reduced by the excess.

Offset Amount

If you are eligible for any of the following benefits or other amounts, the total of all monthly benefits and other amounts plus the pro-rated amount of any lump sum payments will be subtracted from the Schedule Amount:

- 50% of any salary, wages, partnership or proprietorship draw, commissions or similar pay you are eligible to receive from any work you do.
- any payments from a formal or informal salary continuance or sick leave plan sponsored by your employer, the *policyholder*, or an *associated company*.
- any earnings that you could receive if you were working to your *maximum capacity*.
- group disability benefits from any *other plan*.
- disability benefits from the United States Social Security Act, including dependent benefits, payable because of your *injury*, sickness, or pregnancy.
- disability benefits from a *government plan*, except Social Security.
- any benefits (except medical or death benefits) or any amount received in a settlement or compromise of your rights, under:
 - any Workers' Compensation Act (or a similar law); or
 - the Maritime Doctrine of Maintenance, Wages or Cure.
- retirement benefits from the United States Social Security Act unless your *disability* begins after age 65 and you were already receiving such retirement benefits.
- retirement benefits, disability benefits, or similar benefits (not including your contributions) from a *retirement plan* sponsored by your employer, the *policyholder*, or an *associated company*.

We will not consider any amounts rolled over or transferred into any eligible retirement plan unless such amounts are subsequently withdrawn during the Maximum Benefit Period, at which time we will subtract such amounts retroactively without regard to any other provisions of the *policy*.

Early retirement benefits from a *retirement plan* will be included only if:

- you choose to receive them; or
- they would not reduce the normal retirement benefit under the *retirement plan* sponsored by your employer.
- retirement benefits from a *government plan*.

LONG TERM DISABILITY INSURANCE (continued)

- any group disability insurance contract, including one sponsored by your employer, the *policyholder*, or an *associated company*.
- disability benefits from any plan or arrangement, whether insured or uninsured, through your employer, the *policyholder*, or an *associated company* or through any group, association, union or other organization.
- any *no-fault motor vehicle coverage*, unless:
 - state law or regulation does not allow group disability benefits to be reduced by benefits from *no-fault motor vehicle coverage*; or
 - the *no-fault motor vehicle coverage* determines its benefits after benefits have been paid under the *policy*; or
 - the benefits are provided under optional coverage.
- any amount you receive of a type included in your *monthly pay* for the purpose of determining your *long term disability insurance* benefit under the *policy*.
- any amount you receive from a third party (including any amount you received in a settlement or compromise) in connection with a *disability* which you suffered because of an act or omission of the third party.
- any amount you receive (including any amount you received in a settlement or compromise) because of a claim for any of the sources listed in the Offset Amount.

Estimate of Benefits or Other Amounts

If:

- you are eligible for benefits or other amounts from any of the above sources; or
- it is reasonable to believe that you would be paid such benefits or other amounts if you had applied for them or had applied for them on time;

we will figure your monthly benefit as though you are receiving these other benefits or amounts, even if you are not.

We will:

- estimate the amount of your Social Security benefit; and
- offset that amount as described above;

until we receive notice of a denial of such benefits at the first level of appeal after an initial denial.

We will adjust your monthly benefit when we receive proof that such benefits or other amounts are not payable or are denied.

Social Security Assistance

Your claim for Social Security disability benefits may be denied up to the reconsideration level. If it is, we will have it reviewed by an *SSA representative*, at your request.

If we consider you a good candidate, we will start this process. We will give you a list of *SSA representatives*. If you choose from this list, we will pay their fee.

Whether you use our help or not, we will reimburse you for the fee charged you by your *SSA representative*. In order to obtain this reimbursement, you must become entitled to Social Security disability benefits while eligible for benefits under our *policy*. If you are no longer eligible for benefits under the *policy* but then become entitled to

LONG TERM DISABILITY INSURANCE (continued)

Social Security disability benefits retroactive to a date while you were still eligible for benefits under the *policy*, we will reimburse you for the fee charged you by an *SSA representative*. Our reimbursement is limited to the fee approved by the Social Security Administration. We may reduce any overpayment calculated in our claim.

Adjustment of Benefits

If we find that the amount of benefit which we should have paid is different from the amount of benefit we actually paid you, we will adjust your benefit.

If we paid you less than we should have, we will pay you the difference.

If we paid you more than we should have, you must reimburse us. Any future benefits we determine to be due, including the Minimum Benefit, will be applied to the overpayment until we are reimbursed in full.

We may also reduce or stop paying benefits until any overpayment made to you under a Short Term Disability plan issued by us to the *policyholder* is recovered. If we reduce your benefit, or stop paying benefits, the Minimum Benefit will not be payable.

Lump Sum Benefit

If you receive benefits from any source in a lump sum, we will pro-rate it over the time in which it accrued, based on information from the source of the payment. If we do not receive all the information we need, we will pro-rate the payment according to its nature and purpose.

Benefit Freeze

We will not reduce your monthly benefit further if the amount of benefits from any source, other than the *policy*, changes because of a cost of living increase that occurs automatically or by law after you satisfy the *qualifying period*.

Rehabilitation Benefit

Rehabilitation Plan for You

You may ask to participate in a *rehabilitation plan* while you are *disabled*. We have the sole discretion to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed upon by you and us.

While you are participating in your *rehabilitation plan*, we will increase your Schedule Amount by 10% of your *monthly pay* or \$1,000, whichever is less. During this period, your Schedule Amount may exceed the maximum Schedule Amount in the Schedule.

The *rehabilitation plan* may include, at our discretion, payment of your *medical expense, education expense, moving expense, accommodation expense or family care expense*.

If you return to work as part of a *rehabilitation plan* while you are *disabled*, we will pay your employer:

- 100% of your salary, wages, partnership or proprietorship draw, commissions, or similar pay; or
- the Schedule Amount, if less;

for the first month after you return to work, or your remaining *period of disability*, if less.

If your *disability* ends while you are participating, with your full cooperation, in your *rehabilitation plan*, and you are not able to find gainful work, we will:

- pay you the amount of benefit, other than rehabilitation benefits, that would have been payable to you if you had remained *disabled* until:
 - 3 months after your *disability* ends; or
 - the date you are able to find gainful work, if earlier; and

LONG TERM DISABILITY INSURANCE (continued)

- provide or pay for reasonable job placement services for a period of up to 3 months after your *disability* ends.

Rehabilitation Plan for Your Spouse

You and your spouse may ask to participate in a *rehabilitation plan* for your spouse while you are *disabled* if:

- you are receiving disability benefits from a *social security plan*; and
- your spouse's earnings in the six calendar months prior to your *disability* averaged less than 60% of your *monthly pay*.

We have the sole discretion to approve or deny your request. The terms and conditions of the *rehabilitation plan* must be mutually agreed by you, your spouse, and us.

The *rehabilitation plan* for your spouse may include, at our discretion, payment of your spouse's *education expense*, reasonable job placement expenses, and the family's *moving expense*, if any. It may also include *family care expense* incurred by your spouse, necessary in order for your spouse to be retrained under the *rehabilitation plan*.

We will reduce the amount of your benefit we pay you by 50% of any salary, wages, partnership or proprietorship draw, commissions, or similar pay from any work your spouse does as a result of participating in your spouse's *rehabilitation plan*. If your spouse is working when your spouse's *rehabilitation plan* begins, we will only reduce your benefit by 50% of the increase in income that results from your spouse's participation in your spouse's *rehabilitation plan*.

Exclusions

We will not pay benefits for any time you are confined to any facility because you were convicted of a crime or public offense.

We will not pay benefits for any part of a *period of disability* due to drug addiction or chemical dependency.

We will not pay benefits for any *disability* caused by:

- war or any act of war, whether declared or not;
- participating in any sport for wage, compensation or profit;
- racing any type of vehicle in an organized event;
- participating in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance, unless administered by a *doctor* or taken according to the *doctor's* instructions;
- your *intoxication*; this includes but is not limited to operating a motor vehicle while you are *intoxicated*;
- intentionally self-inflicted injury, while sane or insane; or
- taking part in or the result of taking part in committing a felony.

We will not pay benefits if:

LONG TERM DISABILITY INSURANCE (continued)

- your employer, the *policyholder*, or an *associated company* has offered you the opportunity to return to limited work while you are *disabled*;
- you are functionally capable of performing the limited work which is offered; and
- you do not return to work when and as scheduled.

Benefits will end as of the date you were first scheduled to return to work. Subject to the terms of the *policy*, benefits will recommence on the earlier of the date you return to such work, if you remain *disabled*, or the date your *disability* worsens so that you are no longer capable of such work.

Special Conditions

We pay only a limited benefit for a *period of disability* due to *special conditions*. The Maximum Benefit Period for all such *periods of disability* is 12 months. This is not a separate maximum for each such condition, or for each *period of disability*, but a combined maximum for all *periods of disability* and for all of these conditions.

Your *period of disability* will be considered due to *special conditions* if:

- you are limited by one or more of the stated conditions; and
- you do not have other conditions which, in the absence of the stated conditions, would continue to exist, limit your activities, and lead us to conclude that you were *disabled*.

Benefits may be payable for more than 12 months, but not beyond the Maximum Benefit Period in the Schedule, if you

- are *hospital confined* at the end of the 12-month period above, and
- remain *disabled*.

Benefits will be payable for the length of your confinement and for up to 60 days following the end of your confinement.

If you are *hospital confined* again during the 60-day period for at least 10 consecutive days, benefits will be payable for the length of the second confinement and for up to 60 days following the end of the second confinement.

Pre-Existing Conditions

We will not pay benefits for any *disability* resulting, directly or indirectly, from a pre-existing condition (defined below) unless the *disability* begins after 12 consecutive months during which you are continuously insured under the *long term disability insurance policy*.

A "pre-existing condition" means an *injury*, sickness, pregnancy, symptom or physical finding, or any related *injury*, sickness, pregnancy, symptom or physical finding, for which you:

- consulted with or received advice from a licensed medical or dental practitioner; or
- received medical or dental care, treatment, or services, including taking drugs, medicine, insulin, or similar substances

during the 3 months that end on the day before you became insured under the *long term disability insurance policy*.

If your *disability* results from more than one condition, we will determine whether you would be *disabled* in the absence of all pre-existing conditions. If we conclude that you are *disabled* by one or more conditions which are not pre-existing conditions, we will consider your claim as not resulting from a pre-existing condition for so long as this remains true.

LONG TERM DISABILITY INSURANCE (continued)

Extended Benefit

If you are *disabled* on the day your *long term disability insurance* ends, and if you remain *disabled* long enough to qualify, we will pay benefits according to the *policy*.

Conversion Privilege

If your *long term disability insurance* ends, you may be able to convert to coverage provided under a conversion policy. You must have been insured under the *policy* for at least a year. This includes time insured under any similar group policy which the *policy* replaces.

Within 31 days after your insurance ends, you must:

- apply for coverage under the conversion policy; and
- pay the first premium.

Proof of good health is not required.

You cannot convert if your *long term disability insurance* ends because:

- the *policy* ends;
- the *policy* is changed to end your coverage;
- you are *disabled*;
- a required premium is not paid; or
- you retire from your employer, the *policyholder*, or an *associated company*.

The benefits of the conversion policy will be those we offer for conversion at the time you apply. The premium will be based on rates in effect for conversion policies at that time. The effective date of coverage will be the day after your insurance under the *policy* ends.

Survivor Benefit

If you die while entitled to benefits under the *policy*, we will pay a survivor benefit. We must receive proof of your death and proof that the person claiming the benefit is entitled to it. We will pay the survivor benefit only to your lawful spouse, if living, otherwise, to your children. Children must be unmarried, and under age 21 or, if a full-time student, age 25. "Children" include step-children or foster children that depended on you for support and maintenance. Adopted children are also included.

The monthly survivor benefit equals the monthly benefit payable under the *policy* for your last full calendar month of *disability*. If no benefit was paid for a full calendar month, a survivor benefit for a full month will be determined.

The survivor benefit is payable on:

- the first of the month after your death; and
- the first of each of the next 2 months.

If no one entitled to the survivor benefit is living on the first of any month after your death, we will not pay a survivor benefit.

Payment of the survivor benefit is subject to the other provisions of the *policy*.

CLAIM PROVISIONS

Payment of Benefits

We will pay benefits at the end of each month (or shorter period) for which we are liable, after we receive the required proof. If any amount is unpaid when *disability* ends, we will pay it when we receive the required proof.

To Whom Payable

We will pay all benefits to you. However, if medical evidence indicates that a legal guardian or conservator should be appointed, we will pay benefits to such guardian or conservator. Until such time as a legal guardian or conservator is appointed, the company may, at its sole discretion, hold further benefits due or make payments to any relative by blood or marriage, or to any other person or institution appearing to have assumed custody and principal support of you. The company shall be discharged from all liability to the extent of such payments.

If any amount remains unpaid when you die, we will pay your estate.

Authority

The *policyholder* delegates to us and agrees that we have the authority to determine eligibility for participation or benefits and to interpret the terms of the *policy*. However, this provision will not restrict any right you may have to pursue an appeal or file a lawsuit if your claim for benefits is denied.

Filing a Claim

1. You must send us notice of the claim. We must have written notice of any insured loss within 30 days after it occurs, or as soon as reasonably possible. You can send the notice to our *home office*, to one of our regional group claims offices, or to one of our agents. We need enough information to identify you as a *covered person*.
2. Within 15 days after the date of your notice, we will send you certain claim forms. The forms must be completed and sent to our *home office* or to one of our regional group claims offices. If you do not receive the claim forms within 15 days, we will accept a written description of the exact nature and extent of the loss.
3. The time limit for filing a claim is 90 days after the end of the first month (or shorter period) for which we are liable.
4. To decide our liability, we may require:
 - proof of benefits from other sources, and
 - proof that you have applied for all benefits from other sources, and that you have furnished any proof required to get them.

Proof of Loss

Within 30 days of the start of your *disability*, you should give us proof that you are currently *disabled* and have been continuously *disabled* since your last day of *active work*. Proof must be given within 90 days after the end of your *qualifying period*. If proof of loss is first received by us more than 180 days after the end of the *qualifying period*, your Schedule Amount will be reduced by 30%.

Continuing proof of *disability* must be given as often as we may reasonably require. Continuing proof must be given within 60 days of our request.

You must provide us with all of the information we specify as necessary to determine proof of loss and decide our liability. This may include but is not limited to medical records, hospital records, pharmacy records, test results, therapy and office notes, mental health progress notes, medical exams and consultations, tax returns, business records, Workers' Compensation records, payroll and attendance records, job descriptions, Social Security award and denial notices, and Social Security earnings records.

CLAIM PROVISIONS (continued)

You must provide us with a written authorization allowing the sources of medical, vocational, occupational, financial, and governmental information to release documents to us which enables us to decide our liability. If you do not provide us with continuing proof of *disability* and the items and authorization necessary to allow us to determine our liability, we will not pay benefits.

Right to Examine or Interview

We may ask you to be examined as often as we require at any time we choose. We may require you to be interviewed by our authorized representative. We will pay third party charges for any independent medical exam or interview which we require. If you fail to attend or fully participate, we will not pay benefits.

Limit on Legal Action

No action at law or in equity may be brought against the *policy* until at least 60 days after you file proof of loss. No action can be brought after the applicable statute of limitations has expired, but, in any case, not after 3 years from the date of loss.

Review Procedure

You must request, in writing, a review of a denial of your claim within 180 days after you receive notice of denial.

You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits, and you may submit written comments, documents, records and other information relating to your claim for benefits.

We will review your claim after receiving your request and send you a notice of our decision within 45 days after we receive your request, or within 90 days if special circumstances require an extension. We will state the reasons for our decision and refer you to the relevant provisions of the *policy*. We will also advise you of your further appeal rights, if any.

Incontestability

The validity of the *policy* cannot be contested after it has been in force for 2 years, except if premiums are not paid.

Any statement made by the *policyholder* or a *covered person* will be considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to the *covered person* or the *beneficiary*.

No statement, except fraudulent misstatement, made by a *covered person* about insurability will be used to deny a claim for a loss incurred or *disability* starting after coverage has been in effect for 2 years.

No claim for loss starting 2 or more years after the *covered person's* effective date may be reduced or denied because a disease or physical condition existed before the person's effective date, unless the condition was specifically excluded by a provision in effect on the date of loss.

GENERAL PROVISIONS

Entire Contract

The *policy* and the *policyholder's* application attached to it are the entire contract. Any statement made by you or the *policyholder* is considered a representation. It is not considered a warranty or guarantee. A statement will not be used in a dispute unless it is written and signed, and a copy is given to you.

Errors

An error in keeping records will not cancel insurance that should continue nor continue insurance that should end. We will adjust the premium, if necessary, but not beyond 3 years before the date the error was found. If the premium was overpaid, we will refund the difference. If the premium was underpaid, the difference must be paid to us.

Misstatements

If any information about you or the *policyholder's* plan is misstated or altered after the application is submitted, including information with respect to participation or who pays the premium and under what circumstances, the facts will determine whether insurance is in effect and in what amount. We will retroactively adjust the premium.

Certificates

We will send certificates to the *policyholder* to give to each *covered person*. The certificate will state the insurance to which the person is entitled. It does not change the provisions of the *policy*.

Workers' Compensation

The *policy* is not in place of, and does not affect any state's requirements for coverage by Workers' Compensation insurance.

Agency

Neither the *policyholder*, any employer, any *associated company*, nor any administrator appointed by the foregoing is our agent. We are not liable for any of their acts or omissions.

Fraud

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial or termination of benefits or coverage under the *policy* and recovery of any amounts we have paid.

SUMMARY PLAN DESCRIPTION

This Summary Plan Description is issued to you in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Included within this document is your Certificate of Insurance, issued by Union Security Insurance Company in compliance with state law. Your Summary Plan Description does not replace or modify the Master Policy issued by Union Security Insurance Company in any way. The Master Policy is the contract which sets forth the terms and conditions of the benefits the Plan Sponsor chose to provide in its welfare benefit plan. The Master Policy may be amended at any time by agreement between the Plan Sponsor and Union Security Insurance Company. The Master Policy may be terminated at any time by the Plan Sponsor or may be terminated by Union Security Insurance Company for non-payment of premium or for failure to meet the Master Policy's minimum participation requirements. The Plan Administrator has the obligation to prepare, issue, amend and file the Summary Plan Description (SPD) and is solely responsible for its contents.

GENERAL ADMINISTRATIVE PROVISIONS

Name of the Plan:

St. Francis Health Services of Morris, Inc.

Plan Sponsor:

St. Francis Health Services of Morris, Inc.
801 Nevada Ave
Morris, MN 56267
320.589.2004

Employer I.D. Number:

41-1484416

Type of Plan:

An employee welfare plan providing benefits for:

Long Term Disability Insurance

Plan Number:

PN501 unless another number is assigned by the employer, the Plan Administrator, or on any Form 5500 filed for the Plan.

Effective Date:

The plan, as described in this SPD, became effective on January 1, 2015.

Who Is Eligible:

Eligible Class: Each full-time employee of the policyholder or an associated company,
• whose monthly pay is greater than or equal to \$1,000, and
• who is at active work, and
• who is working in the United States of America,
as identified on the policyholder's or our records, except any temporary or seasonal worker.

Service Requirement: 60 days

Entry Date: An eligible person will become insured on the first of the month occurring on or after the day all eligibility requirements are met.

Full-time means working an average of at least 56 hours per pay period.

The plan may also cover other persons not included above. Check with the plan administrator.

Plan Administrator:

St. Francis Health Services of Morris, Inc.
801 Nevada Ave
Morris, MN 56267
320.589.2004

Type of Administration:

This plan is insured by a contract with Union Security Insurance Company, 2323 Grand Boulevard, Kansas City, Missouri 64108.

**Amendment or
Termination of Plan:**

This plan may be amended or terminated at any time by the Plan Sponsor.

**Agent for Service of
Legal Process:**

St. Francis Health Services of Morris, Inc.
801 Nevada Ave
Morris, MN 56267
320.589.2004

Plan Records:

The fiscal records for the plan are kept on a policy year basis ending each December 31.

Cost of Benefits:

The premiums for the Long Term Disability Insurance plan are paid for entirely by you.

Your plan includes:

Long Term Disability Insurance

The benefits, limitations and exclusions are described in the Certificate which is found within this Description.

STATEMENT OF 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 provides that all plan participants shall be entitled to:

- (i) 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, if required, a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- (ii) Obtain, upon written request to the plan administrator, copies of all documents governing the plan including insurance contracts and collective bargaining agreements, and, if required, copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The administrator may make a reasonable charge for the copies.
- (iii) 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.

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 our 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. If your claim for welfare benefits is denied 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 certain materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay 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 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 may 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 legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. 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 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.

CLAIMS PROCEDURE

The following procedures apply to the extent benefits under your employee benefit plan are insured under a contract issued by Union Security Insurance Company.

PRESENTING A CLAIM

Contact your plan administrator, who will advise you of any forms which are required. These forms should be returned to the Plan Administrator after completion. This Administrator will review them, complete any information concerning eligibility and forward them to Union Security Insurance Company. Time limits for filing the claim and other requirements for notice and proof of loss may be found under the heading, "Filing A Claim".

NOTIFICATION OF DECISION—DISABILITY

A decision will be made within 45 days after receipt by Union Security Insurance Company of a properly executed, complete proof of loss unless circumstances beyond the control of the Plan require an extension of time for processing the claim. Such an extension of time may not exceed 30 additional days unless circumstances beyond the control of the Plan require a second extension, not to exceed an additional 30 days. If the claim is denied in whole or in part, Union Security Insurance Company will provide written notice either directly to you or to the Plan Administrator for delivery to you. The written notice will contain:

1. The specific reason or reasons for the denial;
2. Specific reference to pertinent provisions of the policy upon which the decision is based;
3. A description of any additional material or information needed to perfect the claim and an explanation of why it is necessary; and
4. An explanation of the plan's claim review procedure.

AUTHORITY

The Plan Sponsor delegates to Union Security Insurance Company and agrees that Union Security Insurance Company has the authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. However, this provision will not restrict any right you may have to pursue an appeal or file a lawsuit if your claim for benefits is denied.

REVIEW PROCEDURE—DISABILITY

You are entitled to a full and fair review of denial of claim. You may make a request to the Plan Administrator or appropriate named fiduciary, if other than the Plan Administrator. The procedure is as follows:

1. The request for review must be in writing and made within 180 days of receipt of written notice of denial;
2. You have the right to review, upon request and free of charge, copies of all documents, records, and other information relevant to your claim for benefits. You have the right to review copies of any internal rule, guideline, protocol or other similar criterion that was relied upon in making our decision to deny your claim. You have the right to submit issues and comments in writing, along with additional documents, records, and other information relating to your claim;
3. The Plan Administrator will forward the request to Union Security Insurance Company;
4. Union Security Insurance Company will make a decision upon review within 45 days after receipt of the request unless special circumstances require an extension of time for processing in which case the time limit shall not be later than 90 days after receipt. The decision or review will be in writing, include the specific reasons for the decision and specific references to the pertinent plan provisions on which the decision is based and be furnished either directly to you or to the Plan Administrator for delivery to you.



ASSURANT

Employee
Benefits

2323 Grand Boulevard
Kansas City, MO 64108

Policy 4054637
Participant 0
Booklet 4
3/18/2015