Short Term Disability
Summary Plan Description

Effective Date: January 1, 2023

Contact Information

Plan Administrator: Sagewell Healthcare Benefits Trust
Edward W. Sparrow Hospital Association
Address and Telephone #:1501 Reedsdale Street, Suite 3005, Pittsburgh, Pennsylvania, 15233-2341
(800) 872-0277

Claims Administrator: UNUM
Address and Telephone #: 2211 Congress St, Portland ME 04122, (800)858-6843

Service Provider: UNUM
Address and Telephone #: 2211 Congress St, Portland ME 04122, (800)858-6843

Disclosure

The following Summary Plan Description (SPD) template is not intended to constitute legal advice but is provided for your review with your attorneys or other professional advisors.

We encourage you to discuss this template with your attorney to determine if it is appropriate for your use. If you decide to use it, fill in the appropriate information and provide copies to the individual participants of your Plan.

Content Checklist for Summary Plan Description (SPD)

- ☐ Name of plan:
- ☐ Name and address of sponsor:
- ☐ Employer tax ID number:
- ☐ Plan number (chosen by employer):
- ☐ Type of plan (line of coverage):
- ☐ Type of administration:
- ☐ Date the plan year ends:
- ☐ Name, business address and telephone number of PA:
- ☐ Name and address of person who services as agent for service of legal process:
- ☐ Source and method of financing for the plan and identity of entity that provides benefits:
- ☐ Source of contributions to plan:
- ☐ Benefit terms:
- ☐ Administration of benefit claims and appeals:
- ☐ Statement of ERISA rights:

The full details of the required contents of an SPD are set forth in the DOL regulations at 29 CFR Section 2520. 102-3, which can be found online at: GPO: U.S. Government Publishing Office Keeping America Informed: Electronic Code of Federal Regulations

Important: This page is not to be included in the ***final SPD document.*** This is only a guide and should be deleted prior to completing the document.

Table of Contents

Overview of Plan

The Plan is a short term disability income protection benefit plan ("Plan" or "Short Term Disability Plan") sponsored by us to replace a portion of your income in the event a sickness or injury prevents you from working for a period of time. This Plan does not provide benefits for occupational injuries or sicknesses. Detailed information about your eligibility for coverage, what benefits are payable, how to file a claim, and other features of this Plan are contained in this document, which is referred to as your booklet.

The Plan is funded as provided in the Summary of Benefits section of this booklet. We have engaged Unum to provide certain administrative claims handling services for the Plan. Neither Unum nor any of its affiliates or related insuring entities ensures the benefits under this Plan or has any responsibility to fund benefits under the Plan.

We reserve the right to modify, amend, suspend or terminate, in whole or in part, any of the provisions of this Plan at any time for any reason or for no reason. When making a benefit determination under the Plan, we have discretionary authority to determine your eligibility for benefits and to interpret and enforce the terms and provisions of the Plan. We may delegate some or all of this authority to Unum at any time.

"We", **"us"**, and **"our"**, as used in this overview, refer to the Employer identified on the cover page. The Employer is the Plan's sponsor.

This booklet is written in plain English. If you do not understand any of the terms in it, or desire more information, you should contact us using the contact information on the cover page. Many of the terms used in this booklet are defined in the Definitions Section. Be sure to read all the definitions so that you will understand the Plan fully.

BENEFITS AT A GLANCE
SHORT TERM DISABILITY PLAN

This short term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER: Edward W. Sparrow Hospital Association

January 1, 2023 916468

ELIGIBLE GROUP(S):

To be eligible for benefits, you must be a member of the following eligible group:

Class 1: Full Time Residents and Full-Time and Part-Time Physicians and UAW Salaried Caregivers
Class 2: Full and Part-Time Non-Represented Salaried Caregivers
Class 3: Full-Time Hourly UAW Caregivers
Class 4: Full-Time Hourly Non-Represented Caregivers
Class 5: Full-Time MNA Salaried Caregivers
Class 6: Part-Time MNA Salaried Caregivers

MINIMUM HOURS REQUIREMENT:

To be eligible for benefits, you must meet the following requirements:

Class 1: **Physicians** must be working at least **8** hours per week; **Residents** must be working at least **40** hours per week; **UAW Salaried Caregivers** must be working at least **24** hours per week.
Class 2: Full time employees must be working at least **36** hours per week; Part time employees must be working at least **24** hours per week
Class 3 & 4 & 5: employees must be working at least **36** hours per week
Class 6: employees must be working at least **16** hours per week

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

WAITING PERIOD:

For employees in an eligible group **Class 1, 2, 5 & 6**: First of the month following 0 days

For employees in an eligible group **Class 3 & 4**: First of the month following 12 months

HOW THE PLAN IS FUNDED:

We pay 100% of the cost of funding the Plan

ELIMINATION PERIOD:

The later of:

Class 1:
- **0** days for disability due to an injury; or
- **0** days for disability due to a sickness

Class 2:
- **7** days for disability due to an injury; or
- **7** days for disability due to a sickness

Class 3:
- **6** scheduled days for disability due to an injury; or
- **6** scheduled days for disability due to a sickness

Class 4:
- **6** calendar days for disability due to an injury; or
- **6** calendar days for disability due to a sickness

Class 5:
- **3** scheduled workdays for disability due to an injury; or
- **3** scheduled workdays for disability due to a sickness

Class 6:
- **2** scheduled workdays for disability due to an injury; or
- **2** scheduled workdays for disability due to a sickness

Benefits begin the day after the elimination period is completed.

WEEKLY BENEFIT:

[X%] of weekly FTE hours to a maximum benefit of **[$X]** per week

Your payment may be reduced by deductible sources of income and in some cases by the income you earn while disabled.

MAXIMUM PERIOD OF PAYMENT:

Class 1 & 2: End of disability or 120 days
Class 3 & 4: 90 days
Class 5 & 6: 120 days

Premium payments are required for your coverage while you are receiving payments under the Plan.

OCCUPATIONAL INJURIES

Your Short Term Disability Plan does not cover disabilities due to an occupational sickness or injury.

OTHER FEATURES:

Minimum Benefit
Survivor Benefit
The Plan includes enrollment, risk management and other support services related to our Plan.

CLAIM INFORMATION

SHORT TERM DISABILITY

WHEN DO YOU NOTIFY THE SERVICE PROVIDER OF A CLAIM?

We encourage you to notify the Service Provider of your claim as soon as possible, so that a claim decision can be made in a timely manner. Notice of a claim should be sent to the Service Provider within 30 days after the date your disability begins. In addition, you must send the Service Provider written proof of your claim no later than one year after the date your disability begins unless failure to do so is due to your lack of legal capacity. In no event can proof of your claim be submitted after the expiration of the time limit for commencing a legal proceeding as stated in the Plan, even if your failure to provide proof of claim is due to the lack of legal capacity or if state law provides an exception to the one year time period.

You must notify the Service Provider immediately when you return to work in any capacity. Unless we have given you different delivery instructions, you should use the contact information on the cover page when notifying Service Provider of your claim.

HOW DO YOU FILE YOUR PROOF OF CLAIM?

You must fill out your own section of the claim form and then send the claim form to the Service Provider. Your physician should fill out his or her section of the claim form and send it directly to the Service Provider.

The form to use to submit your proof of claim is available from us, or you can request the form from our Service Provider. If you do not receive the form

from us or our Service Provider within 15 days of your request, send Service Provider proof of claim without waiting for the form.

Alternatively, you may follow any claims filing procedures approved by us and Service Provider. We will separately advise you of any such procedures.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of your claim, provided at your expense, must show:

- the date your disability began;
- the existence and cause of your sickness or injury;
- that your sickness or injury causes you to have limitations on your functioning and restrictions on your activities preventing you from performing the material and substantial duties of your regular occupation;
- that you are under the regular care of a physician;
- the name and address of any hospital or institution where you received treatment, including all attending physicians;
- the appropriate documentation of your weekly earnings, any disability earnings, and any deductible sources of income.

In some cases, you will be required to give our Service Provider and us authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. You may also be required to send our Service Provider appropriate financial records, which may include income tax returns, which we believe are necessary to substantiate your income. We may request that you send periodic proof of your claim. This proof, provided at your expense, must be received within 45 days of a request. We may deny your claim, or stop sending you payments, if the appropriate information is not submitted.

We or our Service Provider may require you to be examined by a physician, other medical practitioner and/or vocational expert of our or its choice. This examination will be at no cost to you and can be required as often as it is reasonable to do so. We may also require you to be interviewed in person by us or our Service Provider.

TO WHOM WILL PAYMENTS BE MADE?

Payments will be made to you through your paycheck from Sparrow on Sparrow's pay schedule.

WHAT HAPPENS IF YOUR CLAIM IS OVERPAID?

We have the right to recover any overpayments due to:

- fraud;
- any error made in processing a claim;
- disability earnings; or
- deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made which may include reducing or withholding future payments including the minimum weekly payment.

We will not recover more money than the amount we paid you.

Any unpaid premium due for your coverage under the Plan may be recovered by us by offsetting against amount otherwise payable to you under the Plan, or by other legally permitted means.

GENERAL PROVISIONS

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are in an eligible group, the date you are eligible for coverage is the later of:

- the Plan effective date; or
- the day after you complete your **waiting period**.

WHEN DOES YOUR COVERAGE BEGIN?

When we pay 100% of the cost of your coverage under the Plan, you will be covered at 12:01 a.m. at our primary place of business on the date you are eligible for coverage.

When you and we share the cost of your coverage under the Plan, or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. at our primary place of business on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date the Service Provider approves your application.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

Once you are first eligible, if you are absent from work due to injury or sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary **layoff**, and if premium is paid, you will be covered through the end of the month that immediately follows the month in which your temporary layoffs begins.

If you are on a **leave of absence**, and if premium is paid, you will be covered following 90 days in which your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

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

WHEN DOES YOUR COVERAGE END?

Your coverage under the Plan ends on the earliest of:

- the date the Plan is cancelled;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

FRAUD WARNING

We take fraud very seriously. If you, with intent to defraud or knowing that you are facilitating a fraud against us, submit an application or file a claim containing a false or deceptive statement, we will assert all legal and equitable rights against you and pursue all legal and equitable remedies we have against you.

DOES THE PLAN REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Plan does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DO WE ACT AS YOUR AGENT OR UNUM'S AGENT?

For purposes of the Plan, we act on our own behalf or as your agent. Under no circumstances will we be deemed the agent of Unum.

BENEFIT INFORMATION

HOW DO WE DEFINE DISABILITY?

DEFINITION OF TOTAL DISABILITY
You are disabled when we determine that due to your **sickness or injury:**

- you are unable to perform the **material and substantial duties** of your **regular occupation**; and
- you are not working in any occupation.

DEFINITION OF RESIDUAL DISABILITY
You are disabled when we determine that:

- you are limited from performing the **material and substantial duties** of your **regular occupation** due to your **sickness** or **injury**; and
- you have a 20% or more loss FTE hours due to that same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the eight weeks.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

You must be continuously disabled through your **elimination period.** A new elimination period will be applied to each disability.

If your disability is the result of an injury that occurs while you are covered under the Plan, benefits begin on the later of:

- **0 days (Class 1)/7 days (Class 2)/6 scheduled days (Class 3)/6 calendar days (Class 4)/3 scheduled work days (Class 5)/2 scheduled work days (Class 6);** or
- the date your **salary continuation or accumulated sick leave** payments end, if applicable.

If your disability is the result of a sickness, your elimination period is the later of:

- **0 days (Class 1)/7 days (Class 2)/6 scheduled days (Class 3)/6 calendar days (Class 4)/3 scheduled work days (Class 5)/2 scheduled work days (Class 6);** or
- the date your salary continuation or accumulated sick leave payments end, if applicable.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes, provided you meet the definition of disability.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments on the next available pay cycle when we approve your claim, providing the elimination period has been met and you are disabled.

HOW MUCH WILL WE PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your **weekly FTE hours** by **the weekly benefit percentage amount as stated in the benefits in brief specific to your position.**
2. The maximum **weekly benefit** is **as stated in the Benefits at a Glance.**
3. Compare the answer from Item 1 with the maximum weekly benefit. The lesser of these two amounts is your **gross disability payment**.
4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **weekly payment**.

Your weekly payment may be reduced based on your disability earnings.

If, at any time after the elimination period, you are disabled for less than 1 week, we will send you 1/7th of your weekly payment for each day of disability.

WHAT ARE YOUR WEEKLY FTE hours?

"Weekly FTE hours" is referring to how many hours you are budgeted to be scheduled. For example, if you are a 1.0 FTE, you are budgeted to be scheduled 40 hours per week, whereas if you are a 0.9 FTE you are budgeted only 36 hours per week. Overtime and bonus shifts are not considered when reviewing your FTE hours.

WHAT WILL WE USE FOR WEEKLY FTE HOURS IF YOU BECOME DISABLED DURING A LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a covered layoff or leave of absence, we will use your weekly FTE hours in effect just prior to the date your absence begins.

HOW MUCH WILL WE PAY YOU IF YOU ARE DISABLED AND WORKING?

We will send you the weekly payment if you are disabled and your weekly **disability hours**, if any, are less than 20% of your weekly FTE hours.

If you are disabled and your weekly disability hours are from 20% through 80% of your weekly FTE hours, you will receive payments based on the percentage of hours you are losing due to your disability. We will follow this process to figure your payment:

1. Subtract your disability hours from your weekly hours.
2. Divide the answer in Item 1 by your weekly FTE hours. This is your percentage of lost hours.
3. Multiply your weekly payment as shown above by the answer in Item 2.

This is the amount we will pay you for each week.

We may require you to send proof of your disability earnings each week. We will adjust your weekly payment based on your disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records, which may include tax returns, which we believe are necessary to substantiate your income.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

The Service Provider will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive as disability income or disability requirement payments under any:

- [if on/off job] worker's compensation law
- state compulsory benefit act or law
- another group insurance plan
- governmental retirement plan.

2. The amount that you receive:

- under the mandatory portion of any "no fault" motor vehicle plan.
- under Title 46, United States Code Section 688 (The Jones Act).
- from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

3. The amount that you receive as retirement payments under any governmental retirement system. Retirement payments do not include payments made at the later of age 65 or normal retirement age under your Employer's retirement plan which are attributable to contributions you made on a post-tax basis to that system.

Regardless of how retirement payments are distributed, we will consider payments attributable to your post tax contributions to be distributed throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Service Provider will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

4. The amount that you:

- receive as disability payments under your Employer's **retirement plan**.
- voluntary elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 65 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, our Service Provider will consider contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Our Service Provider will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

Service Provider will only subtract deductible sources of income which are payable as a result of the same disability.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

Our Service Provider will not subtract from your gross disability payment under this Plan any income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners

- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- **salary continuation** or **accumulated sick leave** plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum weekly payment is: **[xx]**

We may apply this amount toward an outstanding overpayment.

WHAT IF WE DETERMINE YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits listed in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payments by the estimated amount if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Short Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments listed in the deductible sources of income section and appeal your denial to all administrative levels Service Provider feels are necessary; and
- sign the Service Provider's payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals that Service Provider feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a weekly basis to the end of the maximum period of payment.

HOW LONG WILL WE CONTINUE TO SEND YOU PAYMENTS?

We will send you a payment each week you qualify for benefits up to the **maximum period of payment**. Your maximum period of payment is [x] weeks during a continuous period of disability.

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- when you are able to work in your regular occupation on a **part-time basis** and you choose not to return to work or refuse to the part-time status change;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan;
- the date you fail to submit proof of continuing disability;
- after 120 days of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- **occupational sickness or injury,** however, we will cover disabilities due to occupational sickness or injuries for partners or sole proprietors who cannot be covered by a workers' compensation law.
- intentionally self-inflicted injuries,
- active participation in a riot,
- loss of a professional license, occupational license or certification,
- commission of a crime for which you have been convicted, or

The Plan will not cover a disability due to war, declared or undeclared, or any act of war.

The Plan will not pay a benefit for any period of disability during which you are incarcerated.

WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME AND YOUR DISABILITY OCCURS AGAIN?

1. If your current disability is related to or due to the same cause(s) as your prior disability for which we made a payment:

   We will treat your current disability as part of your prior claim, and you will not have to complete another elimination period when you are performing any occupation for us on a full-time basis for 14 consecutive days or less.

If you go back off of work on the 15th day, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of this plan and you will be required to satisfy a new elimination period.

2. If your current disability is unrelated to your prior disability for which a payment was made:

   We will treat your current disability as part of your prior claim, and you will not have to complete another elimination period when you are performing any occupation for us on a full-time basis for less than 1 full day.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If you do not satisfy Item 1 or 2 above, your disability will be treated as a new claim and will be subject to all of the Plan provisions.

If you become entitled to payments under any other group short term disability plan, you will not be eligible for payments under the plan.

GLOSSARY

ACTIVE EMPLOYMENT means you are working for us for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described in the Benefits at a Glance section.

Your work site must be:

- our usual place of business;
- an alternative work site at the direction of us, including your home; or
- a location to which you job requires you to travel.

Normal vacation is considered active employment.

Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the Plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits.

EMPLOYEE means a person who is in active employment in the United States with us.

EMPLOYER is the entity identified on the cover page, and includes any of our divisions, subsidiaries or affiliated companies named in the BENEFITS AT A GLANCE section. Employer is also referred to as "**we**", "**us**", and "**our**". The Employer is the Plan Sponsor.

GOVERNMENTAL RETIREMENT SYSTEM means a plan which is part of any federal state, county, municipal or association retirement system, including but not limited to, a state teachers retirement system, public employees retirement system or other similar retirement system for state or local government employees providing for the payment of retirement and/or disability benefits to individuals.

GRACE PERIOD means the period of the time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before we subtract deductible sources of income and disability earnings.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means a bodily injury that is the result of an accident and not related to any other cause. Injury which occurs before you are covered under the plan will be treated as a sickness. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

LAW, PLAN OR ACT means the original enactments of any law, Plan or act and all amendments.

LAYOFF or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by us. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIMITED means what you cannot or are unable to do.

MATERIAL AND SUBSTANTIAL DUTIES means duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified.

MAXIMUM CAPACITY means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.

MAXIMUM PERIOD OF PAYMENT means the longest period of time the Plan will make payments to you for any one period of disability.

OCCUPATIONAL SICKNESS OR INJURY means a sickness or injury that was caused by or aggravated by any employment for pay or profit.

PART-TIME BASIS means the ability to work and earn between 20% and 80% of your weekly earnings.

PAYABLE CLAIM means a claim for which we are liable under the terms of the Plan.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

The Service Provider will not recognize You, or your spouse, children, parents or siblings as a as a physician for a claim that you send to them.

PLAN means this Short Term Disability plan.

PLAN SPONSOR means the Employer.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

REGULAR OCCUPATION means the occupation you are routinely performing when your disability begins. The Service Provider will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

RETIREMENT PLAN means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan does not include any plan which is part of any governmental retirement system.

SALARY CONTINUATION OR ACCUMULATED SICK LEAVE means continued payments to you by your Employer of all or part of your weekly earnings, after you become disabled as defined by the Plan. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your weekly payment.

SERVICE PROVIDER means Unum Life Insurance Company of America 2211 Congress Street, Portland, Maine 04122, Telephone Number (800)858-6843.

SICKNESS means an illness or disease.

SURVIVOR, ELIGIBLE means your spouse, if living; otherwise your children under age 25 equally.

WAITING PERIOD means the continuous period of time (shown in the Summary of Benefits) that you must be in active employment in an eligible group before you are eligible for coverage under the Plan.

WE, **US** and **OUR** means your Employer, as identified on the cover page.

WEEKLY BENEFIT means the total benefit amount an employee is eligible for under the Plan subject to the maximum benefit.

WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the Plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means a person who is eligible for coverage under the Plan.
WEEKLY EARNINGS means your gross weekly income from your Employer as defined in the plan.

WEEKLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

YOU means a person who is eligible for coverage under the Plan.

ERISA

If this Plan provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Plan constitute the Plan. Benefit determinations are controlled exclusively by the Plan, your certificate of coverage and the information contained in this document.

Name of Plan:
Sagewell Healthcare Benefits Trust Plan

Name and Address of Employer:

Edward W. Sparrow Hospital Association
1501 Reedsdale Street, Suite 403, Pittsburgh, Pennsylvania, 15233-2341

Plan Identification Number:

a. Employer IRS Identification #: 23-3398131
b. Plan #: 916468

Type of Welfare Plan:

Short Term Disability

Type of Administration:

The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the Plan.

Plan Year Ends:

December 31

Plan Administrator Name, Address, and Telephone Number:

Sagewell Healthcare Benefits Trust Edward W. Sparrow Hospital Association 1501 Reedsdale Street, Suite 403, Pittsburgh, Pennsylvania, 15233-2341
(800) 872-0277

Sagewell Healthcare Benefits Trust Edward W. Sparrow Hospital Association is the Plan Administrator and named fiduciary of this self-insured Plan, with authority to delegate its duties including its fiduciary duties. If there are Trustees for this Plan, you will be notified in a separate communication about the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:

Service of legal process may be made upon the Plan Administrator and any Trustee of the Plan.

Funding and Contributions:

The Plan is funded as provided in the BENEFITS AT A GLANCE section.

EMPLOYER'S RIGHT TO AMEND THE PLAN

We reserve the right, in our sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan

(including any related documents), at any time and for any reason or no reason.

If we cancel the Plan, coverage will end at 12:00 midnight at our primary business location on the last day of the Plan. If the Plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in the Plan. To complete your claim filing, the Service Provider must receive the claim information it requests from you (or your authorized representative), your attending physician and us. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Service Provider directly using the information on the cover page of the Plan.

CLAIMS PROCEDURES

You will receive notice of the decision on your claim no later than 45 days after the Claim is filed. This time period may be extended twice by 30 days if an extension is necessary due to matters beyond the control of the Plan and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected. If an extension is necessary due to your failure to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, your Claim may be decided without that information.

If your Claim for Benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEALS PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the Service Provider determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). You will be notified in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal review period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, your appeal may be decided without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, you will be provided with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

- a statement describing your right to bring a civil suit under federal law;

- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

- the statement that "You or your plan 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."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, 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, 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that 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 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, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the

Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the 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.

DISCRETIONARY ACTS

In exercising our discretionary powers under the Plan, we, as the Plan Administrator, will have the broadest discretion permissible under ERISA and any other applicable laws, and our decisions will constitute final review by the Plan of your claim by the Plan. Benefits under the Plan will be paid only if we decide in our discretion that the applicant is entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms and conditions of the Plan.

Addendum to the "Additional Summary Plan Description Information" included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appeals have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description Information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (3) any disability determination made by

the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(l).